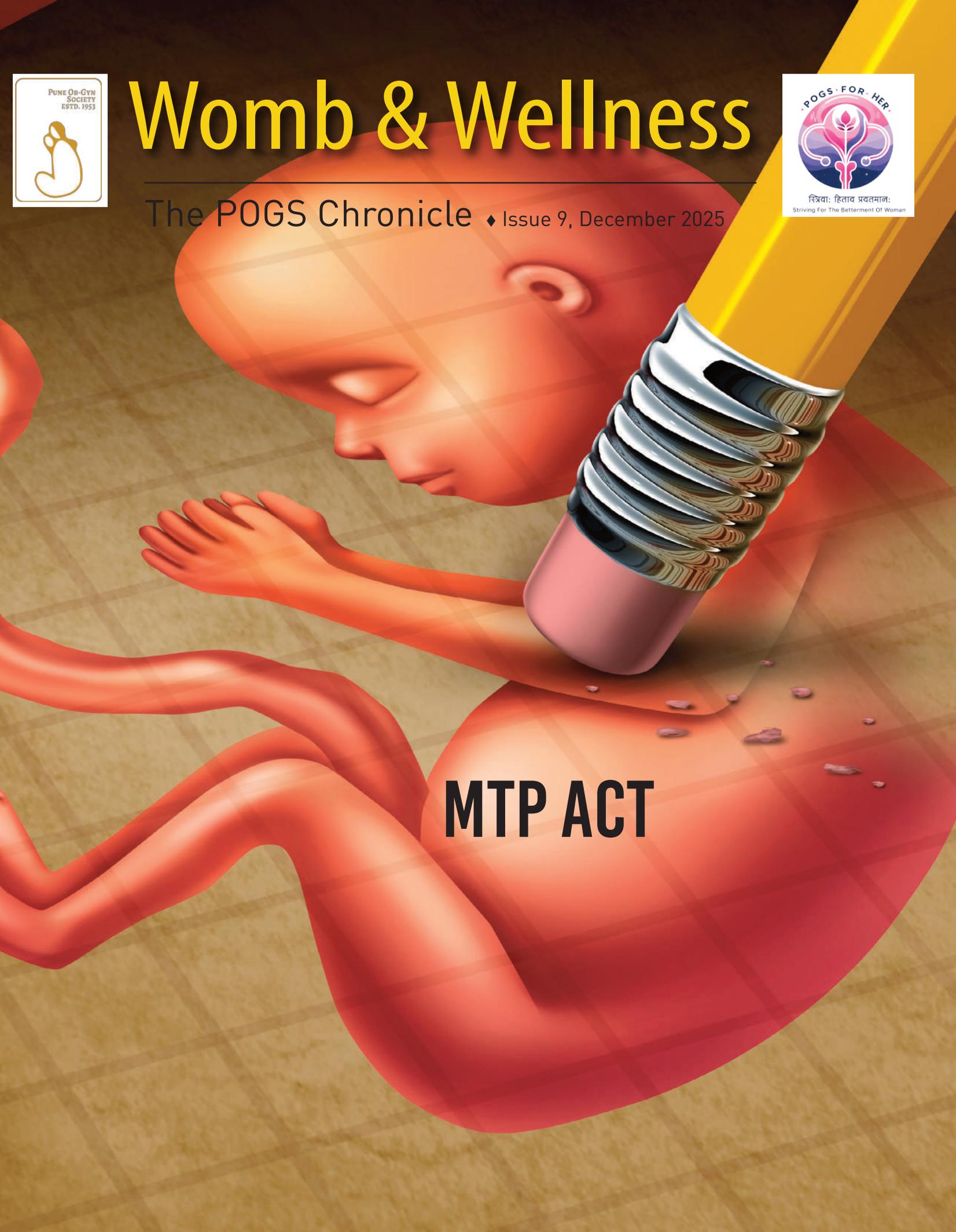


# Womb & Wellness



The POGS Chronicle ♦ Issue 9, December 2025



## MTP ACT

## POGS App

On the auspicious occasion of Gudi Padwa, we are thrilled to announce the launch of the brand-new POGS App, set to debut at our 40th POGS Installation CME!

For the very first time, POGS is bringing you a state-of-the-art mobile application available on both Android and iOS. This app is designed to centralize all POGS-related information, making it easier than ever to stay connected and engaged.

Overview:

- Seamless New Member Registration: Join our community with just a few taps.
- Easy Conference Registration: Book your spots for upcoming events right at your fingertips.
- Monthly Quiz: Test your knowledge and win exciting prizes!
- Digital Library: Access monthly newsletters, a video library, and recordings of past conference lectures

Get ready to experience the convenience and innovation of the POGS App. Stay tuned and be prepared to take your POGS experience to the next level!

**Dr Manish Machave**

President POGS 2025-26

**Dr Nilesh Balkawade**

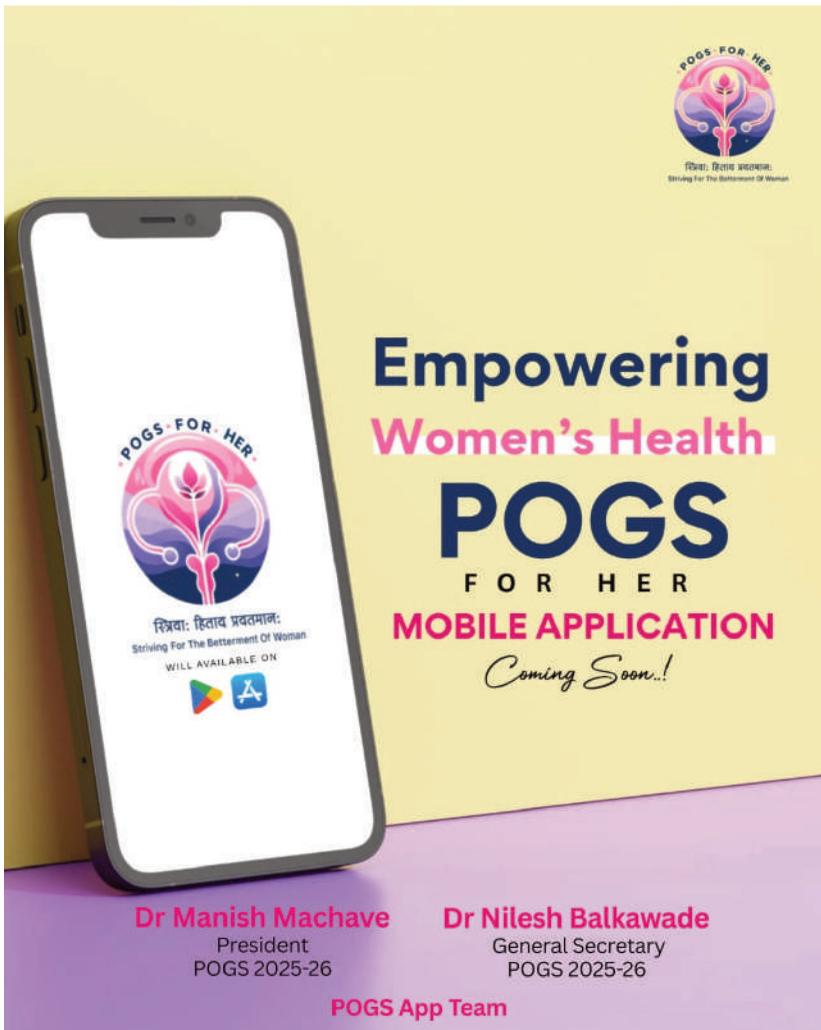
General Secretary

POGS 2025-26

**POGS App Team**

Dr Mahima Lalwani

Dr Mrinmayee Dharmadhikari



The graphic features a smartphone displaying the POGS app interface. The app screen shows the POGS logo, the motto 'नित्रया: हिताय प्रयतमानः' (Striving For The Betterment Of Woman), and the text 'WILL AVAILABLE ON' with Google Play and App Store icons. To the right of the phone, the text reads 'Empowering Women's Health POGS FOR HER MOBILE APPLICATION Coming Soon..!'. At the bottom, the names and titles of Dr Manish Machave (President POGS 2025-26) and Dr Nilesh Balkawade (General Secretary POGS 2025-26) are listed, along with the 'POGS App Team'.



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## Presidential Address

**Dear esteemed member of POGS,**

Greetings from the team,

This is our NINTH, theme based, dedicated and all-encompassing newsletter of POGS.

I begin with enriching words,

“Two roads diverged in a wood, and I, I took the one less travelled by, and that has made all the difference’... Robert frost.

Our choices decide apart from hard work and perseverance as to where we end up.

The subject of abortion in India has long been surrounded by social stigma,

misinformation, and silence. Yet, at its core, the Medical Termination of Pregnancy (MTP)

is a public-health service rooted in autonomy, safety, and the right of every woman to

make informed decisions about her reproductive life. As healthcare providers, it is our

responsibility to highlight the progress made, the challenges that persist, and the urgent

need for continued awareness.

India’s MTP Act, first enacted in 1971 and significantly amended in 2021, remains one of

the more progressive reproductive-health legislations globally. The amendment

extended the gestational limits for termination, allowed a broader range of women to

access services, and strengthened privacy protections. It acknowledged a critical truth:

reproductive choices cannot be restricted by rigid timelines or outdated norms. Instead,

they must adapt to clinical realities and the lived experiences of women.

Despite the legal framework, however, access to safe abortion is far from universal. Many

women—especially adolescents, rural populations, unmarried individuals, and those

with limited health literacy—continue to rely on unsafe or illegal methods. Fear of

judgment, inadequate provider availability, and lack of knowledge about the law create

unnecessary barriers. The consequences are severe: unsafe abortions remain a

preventable cause of maternal morbidity and mortality in India.

Medical abortion, when performed within the recommended gestational period and

under proper medical guidance, is safe, effective, and non-invasive. With the expansion of

telemedicine and improved availability of MTP services in primary healthcare settings,

India has the potential to transform abortion care into a model of community-level

reproductive health. But this requires not just legislation—it requires education,

empathy, and consistent service delivery.

As clinicians and stakeholders, we must ensure that every woman who seeks termination

receives accurate information, timely care, and complete confidentiality. Equally

important is creating a culturally sensitive environment that empowers women rather

than judging them. The conversation around abortion must shift from “permission” to

“rights,” from “stigma” to “support,” and from “silence” to “awareness.”

A safe abortion is not merely a medical procedure; it is an affirmation of a woman’s bodily

autonomy, dignity, and future. As India continues to strengthen its reproductive health

framework, our collective commitment must be clear: no woman should be forced into

unsafe practices when safe, legal, and compassionate care is her right.

I am sure the amalgamation of topics herein shall benefit, guide and help one and all in

their clinical practice.

Do take out time and post us a feedback.

Happy reading.

Looking forward to see you all soon.

TILL THEN “ PUNARDARSHANAY”

NAMASKAR.....



**Dr Manish Machave**  
President, POGS

**Dr Manish Machave**  
**President, POGS**



**Dr Nilesh Balkawade**  
Secretary, POGS

## Secretary's Address

*"When we come together with purpose, knowledge, and compassion, progress is not just possible—it's inevitable."*

Dear Esteemed Members,

The month of November has been filled with meaningful academic activities, impactful public awareness initiatives, and strong community engagement by POGS. I am delighted to share the key highlights with you.

POGS Public Awareness Initiatives  
POGS continues its commitment to serve society beyond the clinic and classroom:

Star Sampurna Conference brought together experts focusing on holistic women's well-being.

We proudly released the Monthly Newsletter on Gyn Oncology, a concise academic resource aimed at continuous learning for all members.

A successful Public Forum on Preconception Counseling was conducted, helping young couples understand the importance of preparedness before pregnancy.

These initiatives strengthen our bond with the community and reflect our responsibility toward women's health.

Upcoming Academic Program

We are honoured to announce the Smith Black Travelling Professorship Program by POGS in association with RCOG and DMH.

Our esteemed international faculty Dr. Amar Bhide will deliver an enriching academic session. I encourage all members to attend this high-value program.

34th POGS Annual Conference – WOW (Womb of Wisdom)

13th & 14th December 2025  
Hotel Sheraton Grand

This year's annual conference promises to be a grand academic celebration with national and international experts, cutting-edge scientific sessions, and interactive deliberations across Obstetrics & Gynecology.

I take this opportunity to warmly invite all members for the:

- Society Dinner
- POGS Awards Night
- Conference Inauguration
- On 13th December after 6 pm at Hotel Sheraton Grand.

Your presence will truly elevate the evening.  
Code Blue Masterclass – Basic & Advanced Life Support for Obstetricians  
13th & 14th December

📍 Hotel Sheraton Grand

A hands-on, lifesaving skill development program designed for all obstetricians to sharpen readiness in emergency scenarios. We urge every member, especially young clinicians, to take full advantage of this opportunity.

### Let's Come Together

As the year approaches its close, let us unite with renewed commitment.

Let's strengthen our society further—by increasing our membership, enhancing participation, and building a powerful academic community.

**Together, we shall continue to raise the standards of women's health in Pune.**

Warm regards,

**Dr. Nilesh Balkawade**  
General Secretary, POGS

## Editorial

### Seasons greetings!

POGS has taken up the task to compile all about MTP as a theme for this month of December 2025. It's one of the very common, frequent & unavoidable procedure for any OBGYN practitioner in day to day practice.

The subject of Medical Termination of Pregnancy (MTP) is one that sits at the intersection of law, medicine, ethics & fundamental human rights. It's a topic that evokes passionate debate, often pitting the "pro-life" versus "pro-choice" ideologies against each other.

Recent legislative amendments in India provide a compelling backdrop for this vital dialogue on prioritizing women's health, dignity & autonomy. For decades, the original MTP Act of 1971 offered a legal pathway to safe abortion, a progressive step that significantly reduced maternal mortality rates caused by unsafe illegal procedures.

However, as the medical technology advanced, revealing fetal anomalies later in the pregnancy & also the safety of procedures in later-term improved, the limit of 20 weeks became a point of contention & a source of immense distress for women & families forced to seek legal interventions. Hence, The MTP (Amendment) Act 2021 represents a step forward in aligning law

with modern medical realities. These amendments aim to provide universal access to comprehensive abortion care & uphold the right to personal liberty, an integral part of a woman's right to privacy, & dignity under the constitution.

The path forward requires more than just legislative tweaks & demands a holistic approach to ensure the spirit of law translates into accessible, non-judgemental healthcare for all women & families. This will include awareness campaigns, infrastructure improvements, sensitization of the service providers & ultimately a focus on contraception. It's important to have the detailed updated knowledge about the advances in technologies, diagnostics, its implementations, medications & procedures related to MTP available today.

Considering the importance of contraception, conception & safe termination of pregnancy at various gestations this chronicle will guide you through the various aspects of MTP penned down by the experienced academicians & practitioners which is a crucial guide for all of us.

Wish you all a safe, enlightening happy reading & learning!

**Dr Kalyani Ingale**  
Editor



**Dr Kalyani Ingale**  
Editor

## Co-Editorial



**Dr Madhu Juneja**  
Director, MOMStory  
Sahyadri Hospital  
Hadapsar Pune  
Chairperson, MTP  
Committee, POGS  
(2025-2026)

Dear colleagues, partners in women's health, and readers of this crucial volume, It is with a profound sense of responsibility and optimism that I pen this address. As the Chairperson of the MTP Committee for POGS, and as a gynecologist who has navigated these delicate waters for two decades, I have witnessed a remarkable evolution in India's legal and social landscape surrounding reproductive rights. This journal, featuring the insightful articles you hold, is not merely a collection of papers; it is a mandate for our profession. The enactment of the Medical Termination of Pregnancy (Amendment) Act, 2021, followed by the landmark Supreme Court ruling in 2022, marks a definitive shift. The law now unequivocally affirms that reproductive autonomy is a fundamental right. It has finally moved past the patriarchal notion that a woman's right to decide rests upon her marital status. The move from 'husband' to 'partner' and the inclusion of unmarried women for the indication of contraceptive failure are powerful statements of equality and dignity.

For us, the practicing clinicians, the message is clear and must resonate through every hospital corridor: Abortion is a legal, ethical, and constitutional right for any woman, not just married women. Our denial of safe services due to archaic social biases is now a violation of reproductive rights. The legal amendments provide us with the necessary framework to reduce unsafe abortions, which, as we all know, remain a significant, preventable cause of maternal mortality. By providing timely, non-discriminatory care, we directly contribute to improved maternal health outcomes and the nation's Sustainable Development Goals.

However, the legal clarity on paper does

not always translate to seamless execution in practice. As several articles in this journal diligently highlight, persistent challenges remain. We must confront the "grey areas". The fear of medico-legal prosecution, the complexity of mandatory reporting under the POCSO Act (especially for minors in consensual relationships), and the ambiguity in the rules governing Medical Boards for late-term abortions still create hurdles.

The Supreme Court's harmonious interpretation of the MTP and POCSO Acts in 2022, protecting the minor's identity in reporting, is a crucial shield for us. Yet, we must actively work to bridge the gap between legal theory and ground reality. This means continuous training, impeccable documentation, and a zero-tolerance policy for disclosing a woman's identity, as mandated by the Act (Section 5A). Improper documentation is one of the most common grounds for medico-legal action, and we must be meticulous. This journal is a call to action. I urge every reader to absorb these insights, to challenge discriminatory social norms, and to become an unwavering champion of women's dignity. Our collective efforts must ensure that the progressive spirit of the MTP Act 2021 fully translates into safe, accessible, and respectful care for every woman across India.

Let us commit to this goal. The trust of our patients, and the future of safe healthcare, depend on it.

# POGS CORE TEAM



**Dr Manish Machave**  
President, POGS



**Dr Nilesh Balkawade**  
Secretary, POGS



**Dr Uma Wankhede**  
President Elect



**Vice President**  
Dr Vaishali Chavan



**Ex Vice President**  
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**Clinical Secretary**  
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**Jt Clinical Secretary**  
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Dr Anagha Pai Raiturkar

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Dr Sanjay Sharma



Dr Swapnali Sansare

# 13th to 15th November 2025 — STAR SAMPOORNA 2025



STAR Sampoorna 2025 unfolded as a magnificent confluence of science, culture, art, and celebration—an experience that truly lived up to its name. At its core was the scientific program, the heartbeat of the conference, bringing together some of the finest minds in the field. With 20 panel discussions, 44 cutting-edge talks, 5 power-packed debates, 4 prestigious orations, and 11 transformative workshops spanning AI to aesthetics and fetal medicine to infertility, Pune transformed into a powerhouse of learning. The academic arena was further elevated by the presence of two distinguished international stalwarts—Prof. Michael Robson and Sir Sabaratnam Arulkumaran—whose expertise added depth, global perspective, and immense value to the proceedings.

The momentum continued into the grand Sampoorna Award Night—an evening of honour and gratitude—with over 100 awards presented to distinguished past presidents, vice presidents, chairpersons, and eminent leaders whose contributions have shaped the fraternity. A celebration of art followed with a spellbinding Ravi Varma Show, where real people brought the iconic paintings of Raja Ravi Varma to life in a breathtaking visual tribute. This seamlessly transitioned into the spectacular Rang-e-Bharat series—an enchanting showcase where each invited state unveiled its heritage through a vibrant 7-minute tapestry of dance, song, narration, and storytelling. Every performance blossomed into a colourful portrait of India's timeless cultural splendour. The evening concluded with the glamorous Starry Night—a fashion showcase inspired by glitz, grace, and



contemporary elegance.

The next chapter of the conclave opened with a soul-stirring and graceful Ganesh Vandana performed by the gifted dancer Piyush Malhotra, invoking divine blessings and setting a serene tone for the proceedings. This was followed by the grand inauguration and the felicitation of over 30 esteemed past presidents,



along with pharma partners, supporters, and contributors who have stood as pillars of strength to the organisation.

The finale brought heartfelt smiles during the Valedictory Ceremony, featuring a unique and memorable skit performed by a talented team—an engaging close that blended humour, reflection, and gratitude.

All of this came together under the visionary leadership of Dr. Sunita Tandulwadkar, Organising Chairperson, whose passion shaped every detail. She was supported tirelessly by Organising Secretaries Dr. Ashwini Kale, Dr. Pooja Lodha, and Dr. Nilesh Balkawade, along with the Scientific Committee led by Dr. Kiran Kurtkoti, Dr. N. Palaniappan, and Dr. Komal Chavan, who curated a truly exceptional academic experience. STAR Sampoorna 2025 shone as a vibrant spectrum of knowledge, culture, and camaraderie—truly a celebration of science with a soul.



## POGS Rotating Trophy 2025

The 17th POGS PG Rotating Trophy Competition was held on Wednesday, 26 November 2025, at K. H. Sanchetti Hall from 3:00 to 8:00 pm.

Dr. Charuchandra Joshi served as the mentor, with Dr. Vaishali Korde Nayak as the Convenor. The Co-Convenors were Dr. Laxmikant Behele and Dr. Meghana Argade.

Two students each from six medical colleges participated: BJGMC, AFMC, Smt. Kashibai Navale Medical College, MIMER, DY Patil Medical College, and YCMH. The Presidential Address was delivered by Dr. Manish Machave. The Welcome Note and Vote of Thanks were presented by Dr. Nilesh Balkawade.

Dr. Charuchandra Joshi gave an overview of the trophy, and Dr. Laxmikant Behele announced the rules of the competition.

AFMC won the trophy, with BJGMC emerging as the runner-up. Winner team-Dr Vaishnavi Ahula and Dr Shipra Sharma. Runner up team- Dr Punam Dudhal and Dr Gargi Gavankar. Four encouragement prizes were awarded, one of which was presented by Dr. Charuchandra Joshi for overall good performance. The judges also shared valuable expert advice.

Felicitation of the winning and runner-up teams was carried out by Dr. Manish Machave.

The program concluded with dinner.





**Dr Ashish Kale**  
Chairperson  
Family welfare  
Committee



**Dr Ashwini Kale**  
Chairperson  
Reproductive  
Endocrine Committee  
FOGSI

## Medical Termination of Pregnancy (MTP) in Special Medical Situations — a practical, evidence-based review

### Abstract

Termination of pregnancy for medical indications or when pregnancy coexists with significant maternal disease requires careful multidisciplinary evaluation, timely counseling, and selection of the safest, most acceptable method. Recent global guidance — especially the World Health Organization's 2022 consolidated Abortion Care Guideline and associated clinical handbook — together with updated society statements (RCOG, ACOG, Society of Family Planning, national frameworks such as India's MTP Amendment Act 2021 and professional society guidance) have clarified clinical pathways, expanded options for medically-indicated and late-gestation terminations, and supported task-sharing, telemedicine, and self-management approaches where appropriate. This review summarises current recommendations, clinical considerations in common special situations, procedural choices, legal/ethical issues, and service delivery principles to optimize outcomes and respect patient autonomy.

### Introduction

Termination of pregnancy (MTP) for non-routine or "special" medical situations includes cases where pregnancy endangers maternal life or health (e.g., severe cardiac disease, malignancy, severe psychiatric illness), pregnancies with major fetal anomalies, pregnancies in minors or survivors of sexual violence, and situations with complex legal/administrative constraints (e.g., pregnancies beyond statutory gestational limits). Across settings, clinical decisions must balance timeliness, maternal safety, fetal prognosis, local legal frameworks, and respect for the pregnant person's values and autonomy. Since 2022, WHO's consolidated guidance and several professional society updates have emphasized evidence-based clinical practice, removal of unnecessary barriers, task-sharing, and flexible

service delivery models (including telemedicine and supported self-management for early medical abortion), all of which are relevant to managing special medical situations.

### Guiding principles for MTP in special medical situations

Key guiding principles include:

1. Urgency and timeliness. For many conditions (e.g., severe maternal disease, rapidly progressive cancer, life-threatening cardiac failure), delays increase maternal risk and compromise prognosis; timely access to MTP is essential.
2. Multidisciplinary decision-making. Complex cases require involvement of relevant specialists (maternal-fetal medicine, cardiology, oncology, psychiatry), anaesthesia, and ethics/legal advisers when necessary. Documentation of clinical rationale and multidisciplinary opinions is crucial.
3. Patient-centred counselling. Present all medically reasonable options (continuation with increased surveillance, termination by available methods), discuss risks/benefits, and respect the patient's informed choice. Counselling must address physical and psychosocial needs and be non-judgmental.
4. Method selection by safety and feasibility. Choice between medical and surgical methods depends on gestational age, maternal comorbidities, local skillset, and facility capacity. For many special situations, surgical approaches in a controlled setting may be preferred; in other cases (e.g., early pregnancy, stable chronic conditions), medical abortion can be safe and feasible.
5. Legal compliance and documentation. Providers must follow national laws (e.g., MTP Amendment Act 2021 in India for gestations beyond certain limits) while advocating for measures that prioritize health and rights. When statutory gestational limits are exceeded, mechanisms such as medical boards or judicial review may be triggered in some ju-

risdictions; however, clinical urgency may sometimes justify expedited institutional review.

### Special clinical scenarios — practical considerations

#### 1. Maternal cardiovascular disease (including cardiomyopathy, valvular disease, pulmonary hypertension)

Pregnancy imposes major hemodynamic changes; in severe cardiac disease (e.g., pulmonary arterial hypertension, severe left ventricular dysfunction, decompensated valvular disease), continuation may carry high maternal mortality/morbidity. Early referral to cardio-obstetric teams is mandatory. Decisions for MTP are based on New York Heart Association (NYHA) class, right-sided pressures, ventricular function, and reversibility. Where termination is chosen, the modality should minimize hemodynamic instability: for early gestations, medical abortion with appropriate monitoring or vacuum aspiration under monitored anaesthesia may be used; for later gestations, surgical termination in an operating theatre with invasive monitoring and experienced anaesthesia is safer. Anticoagulation management and optimization of heart failure therapy must be coordinated.

#### 2. Malignancy in pregnancy

Cancer may require prompt cytotoxic therapy or radiotherapy incompatible with continuation of pregnancy. Multidisciplinary oncology and obstetric consultation should evaluate gestational age, tumor biology, and whether treatment can be modified to preserve pregnancy. When immediate systemic therapy is essential (or teratogenic), MTP is often recommended. When MTP is elected, options depend on gestation: first-trimester surgical or medical abortion; second-trimester procedures performed in tertiary centres with blood-product support; if pregnancy continuation is chosen, chemotherapy regimens with safer profiles in pregnancy may be selected and timing adjusted. Preservation of oncologic tissue samples, clear consent, and psychosocial support are essential.

#### 3. Severe psychiatric illness and suicidal risk

Uncontrolled psychiatric conditions that threaten the pregnant person's safety (e.g., active suicidal ideation exacerbated by pregnancy) may be an indication for termination when less restrictive treatment has failed or is unavailable. Psychiatric assessment should document risk, capacity, and alternatives; emergency MTP may be indicated to prevent imminent harm. Post-MTP

psychiatric follow-up and linkage to services are mandatory.

#### 4. Major fetal anomaly (termination for fetal anomaly — TOPFA)

When prenatal diagnosis reveals a fetal condition incompatible with life or associated with severe lifelong morbidity, TOPFA is commonly considered. Clinical practice varies by legal frameworks and gestational limits; many jurisdictions permit termination beyond standard limits for severe fetal anomaly after multidisciplinary review. Counselling requires clear communication about prognosis, diagnostic certainty (confirmatory testing when feasible), procedural risks, and options for perinatal palliative care. Where delays to decision-making are likely (e.g., awaiting second-trimester anomaly scan or genetic results), expedited pathways and availability of dedicated fetal medicine teams improve care. In several countries, the law allows termination at any gestation for lethal anomalies; where limits exist, medical boards may authorise later terminations.

#### 5. Severe obstetric complications (e.g., pre-eclampsia with severe features, eclampsia, sepsis)

In life-threatening obstetric conditions where delivery is the definitive therapy, termination (or induction/delivery) may be necessary irrespective of gestational age to save the mother. Management focuses on stabilisation (blood pressure control, seizure prophylaxis, sepsis management), arranging delivery in an appropriately resourced setting, and ensuring blood-product and critical care support. Documentation of maternal indications and clear informed consent (or best-interest decisions if the patient lacks capacity) is required.

#### 6. Pregnancies in minors and survivors of sexual violence

Minors and survivors require sensitive, confidential care, trauma-informed counselling, and involvement of paediatric/adolescent specialists and social services as per local law. In many laws, special procedural protections exist (e.g., expedited review, consent by guardian/authority). The clinical goal is rapid access to safe MTP with psychosocial and medico-legal support, preserving the patient's autonomy and safety. Judicial avenues may be necessary when statutory gestational limits are exceeded; courts in some jurisdictions have authorised late terminations in exceptional cases.

### Method selection and modifications for comorbidity

## Early gestation (up to 10 weeks)

Medical abortion (mifepristone + misoprostol) is highly effective and safe and — per WHO and ACOG — can be provided with minimal investigations in many cases. For patients with certain comorbidities (e.g., bleeding disorders, anticoagulation, severe anaemia, or significant cardiac disease), prophylactic optimisation (correction of anaemia, adjustment of anticoagulants), closer monitoring, or choosing a surgical approach may be prudent. Telemedicine-supported medical abortion with clear escalation pathways is acceptable for appropriate patients.

## Second trimester (10–24 weeks and beyond)

Second-trimester termination poses higher procedural risk. Dilation and evacuation (D&E) by experienced providers is commonly used where available. Medical second-trimester abortion (mifepristone + misoprostol or misoprostol alone) is an alternative and is widely supported by specialty guidance when performed in facilities equipped to manage hemorrhage and infection; Society of Family Planning provides clinical recommendations for 14–28 weeks. For patients with cardiac disease, severe anaemia or coagulation issues, operative approaches under controlled anesthesia may be preferred. After the 20–24 week statutory thresholds in some jurisdictions, procedures may require review by medical boards or more extensive documentation.

## Anaesthesia and peri-procedural optimisation

Complex medical comorbidity often necessitates advanced monitoring and specialist anaesthesia input. Regional anaesthesia (where feasible) may be safer than general anaesthesia in certain cardiac conditions, but decisions should be individualized. Blood products, invasive monitoring, and postoperative critical care availability should be planned for high-risk cases.

## Infection control, contraception, and post-procedure care

All patients should be offered evidence-based post-abortion contraception (long-acting reversible contraception when desired). For people with infectious comorbidities (e.g., HIV), standard infection precautions apply; termination does not preclude HIV care and antiretroviral therapy should be continued/adjusted as needed. Post-procedure follow-up can be clinic-based or remote (symptom-based follow-up or low-sensitivity pregnancy testing) depending on context and patient preference. Psychosocial follow-up and referral to supportive services are important, par-

ticularly after pregnancy loss for fetal anomaly or for survivors of violence.

## Legal, ethical and documentation issues

Providers must be familiar with local legal frameworks: for example, India's MTP Amendment Act 2021 expanded grounds and introduced Medical Boards for terminations beyond 24 weeks. In practice, clinicians should document clinical indications, multidisciplinary opinions, counselling content, informed consent, and the rationale for the chosen method. When legal limits constrain care and immediate maternal risk exists, early engagement with institutional legal/ethics teams is advised and, where necessary, escalation to appropriate review bodies or courts for urgent relief (noting that court processes may introduce dangerous delays). Ethical practice emphasizes respect for autonomy, beneficence, non-maleficence, and justice.

## Service delivery innovations relevant to special situations

1. Task-sharing and decentralisation. WHO supports appropriately trained non-physician providers offering aspects of abortion care to expand access; this can reduce delays that worsen outcomes in special situations.
2. Telemedicine and self-management. Early medical abortion with remote support is endorsed by WHO and multiple societies for eligible patients; however, patients with complex comorbidities often require in-person assessment. Telemedicine can expedite triage and initial counselling for those with urgent medical needs.
3. Expedited pathways and multidisciplinary fast-track teams. For pregnancies complicated by severe maternal disease or major fetal anomaly, establishing institutional fast-track referral pathways and multidisciplinary review reduces delay and improves outcomes.

## Practical algorithm (summary)

1. Immediate triage — assess hemodynamic stability, life-threatening features, and capacity.
2. Stabilise — urgent resuscitation, correct reversible factors (e.g., transfuse for severe anaemia).
3. Multidisciplinary review — cardiology/oncology/psychiatry/fetal-medicine as relevant.
4. Counselling and informed consent — document alternatives, risks, and patient choice.
5. Method selection and logistical planning — choose medical vs surgical, arrange anaesthesia/ICU if needed.
6. Perform procedure in appropriate setting — ensure



blood products, monitoring, and surgical backup.  
7. Post-procedure care — contraception, psychological support, follow-up.

#### Research gaps and future directions

Despite stronger evidence for many interventions, gaps remain: high-quality prospective data on termination outcomes in very specific comorbidities (e.g., rare cardiomyopathies), optimal timing of oncologic therapies relative to MTP, and best models for integrated telemedicine plus in-person hybrid care for complex patients. Policy research is also needed to evaluate the effect of legal review mechanisms (e.g., Medical Boards) on timeliness and maternal outcomes. Implementation research should test fast-track multidisciplinary pathways in diverse resource settings.

#### Conclusions

MTP in special medical situations demands rapid, patient-centred, multidisciplinary care. Contemporary guidance from WHO and major professional bodies supports flexible, evidence-based approaches that prioritise maternal safety and autonomy, encourages task-sharing and telemedicine where safe, and highlights the need to remove unnecessary regulatory barriers that delay care. Clinicians should apply these principles within the legal framework of their jurisdiction, ensure clear documentation and robust psychosocial support,

and advocate for systems that permit timely, high-quality care for people facing complex pregnancies.

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Adv. ROHIT ERANDE

## Important Judgments which shaped MTP Act, POCSO Act, and PCPNDT Act

The Oby & Gyn. Specialists apart from keeping their medical knowledge updated and to use their skill, also routinely have to go through the legal frameworks when dealing with reproductive health, child protection, and prenatal diagnostics and the three critical laws governing Oby & Gyn medical practice in these areas are the Medical Termination of Pregnancy (MTP) Act, 1971, the Protection of Children from Sexual Offences (POCSO) Act, 2012, and the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994.

This article is an attempt to peruse in nutshell the important judgments that every doctor in India should be aware of.

### I. Important Judgments related to the MTP Act

The MTP Act, 1971 was passed to ensure the health and safety of women by reducing deaths from unsafe abortions, providing a legal framework for abortion under specific conditions, and protecting the reproductive rights of women and maximum period for MTP was 20 weeks. However slowly, after the opinions of the Medicos, this period was increased by Courts beyond 20 weeks, until a central amendment in the Act was made which permitted abortion upto 24 weeks.

We will the judgments from pre amendment area, that shows how the judiciary trend changed too.

#### 1. Suchita Srivastava V/s. Chandigarh Administration (2009) 9 SCC 1 =AIR 2010 SUPREME COURT 235

**Facts :** A Division Bench of the High Court of Punjab and Haryana by orders dated 9.6.2009 and 17.7.2009, ruled that it was in the best interests of a mentally retarded woman to undergo an abortion. This judgment was assailed by some of the activists on the ground that the high Court ignored the Expert Body's findings which showed that the victim had expressed



her willingness to bear a child. As the case reached Hon'ble Apex Court, it was already 19 weeks.

- The Supreme Court accepted the Expert Body's findings and ruled against the Termination ..
- The Supreme Court held that a woman's right to make reproductive choices is a dimension of her personal liberty under Article 21.
- Consent of a woman—not guardians or the state—is crucial unless she is mentally incapable.

**Relevance for Doctors: Respect patient autonomy; ensure informed consent.**

#### 2. X V/s. Union of India (2017) 3 SCC 458

Issue: Termination beyond 20 weeks for fetal abnormalities.

- The Court allowed the medical termination of a 24-week pregnancy due to severe fetal ab-

normalities (bilateral renal agenesis and anhydramnios).

- The court affirmed that a woman's right to reproductive choice is a component of her right to personal liberty under Article 21 of the Constitution and recognized the importa

### 3. Sarmishtha Chakraborty V/s. Union of India (2018) 13 SCC 339

- SC allowed termination at 26 weeks due to severe fetal abnormalities (Down Syndrome + potential cardiac issues).
- In this Case Honb;e Apex court recognized the reproductive choice as an inseparable part of personal liberty protected under Article 21.
- Reinforced that continuation of pregnancy with severe anomalies causes mental trauma.

### 4. X v. The Principal Secretary, Health & Family Welfare Dept. (2022) 10 SCC 1

This is indeed a landmark judgment related to MTP Act and POCSO Act.

- the Supreme Court of India held that unmarried women have the right to terminate pregnancies between 20 and 24 weeks under the Medical Termination of Pregnancy (MTP) Rules.
- The court found that excluding single women from the provisions of Rule 3B was discriminatory and violated Article 14 of the Constitution.
- It affirmed the right to reproductive autonomy for all women, regardless of marital status, and rejected a narrow, patriarchal interpretation of the law

5 The Doctor saved from paying Rs. 2 Crore compensation. Thanks to 'timely' advise of USG /Anomaly Scans during pregnancy.

### Baby Vani Bhattacharya, through her Father V/s. Dr. Suranjit Dutta, MS, New Delhi, CONSUMER CASE NO. 974 OF 2015

**Facts :** The case is of pre MTP Amendment 2021

1. The present compliant has been filed by a minor baby through her Father against the Doctors alleging them responsible for the delivery of Hydrocephalus baby
2. It was alleged that the mother did inform the Gynec. about her 2 daughters suffering from Autism. But Drs did not pay attention and it was held that the Dr. could have diagnosed the anomalies and delivery of Hydrocephalus baby could have been avoided.

Defense of Doctors : It was submitted that the Opposite Party No. 1 was a qualified Obstetrician and had ex-

perience of 27 years, conducted 8000 to 9000 deliveries including LSCS and other surgeries. It was submitted that though Dr. Dutta advised Triple test and USG at 16 weeks of pregnancy, it was denied by the mother. (documentation)

**Held :** a) It was also held that the patient did not follow the instructions of Dr. Dutta to visit every 15 days, undergo USG and Colour Doppler study. The head circumference (OFC) was measured by the Pediatrician Dr. Dinesh Kumar Goyal, it was 33.5 cm, normal.

b) The Opposite Party No.1 advised proper diagnostic tests during pregnancy to rule out anomaly. It was a reasonable degree of skill and knowledge. Therefore, he cannot be held guilty of negligence by any stretch of imagination.

### 6. "The consent to operate Uterus does not include Consent to remove it "

A Doctor Couple was held negligent for removing uterus of a 25 years patient, without her consent.

**Case Details : DR. RAVINDER VERMA & ANR. V/s. SALMA BEGAM, U.P., REVISION PETITION NO. 968 OF 2015, decided on 14 Feb 2017 –NCDRC.**

### II. Caesarian or Normal Delivery – Whose choice it is?

This topic cannot go untouched which and takes me to the important judgments on the day to day question that Oby and Gyn. practitioners come across and that is Cesarian or Normal Delivery , whose choice it is ?

a. It will not be out of context to mention the important judgment dated 11th March, 2015 of UK Supreme Court in the case of Montgomery (Appellant) V/s. Lanarkshire Health Board (Respondent) (Scotland), wherein it was held that : Also known as "shoulder dystocia judgment"!

#### **Held :**

- Giving birth in the 'NATURAL' way or giving birth by 'CAESAREAN SECTION' (unless she lacks the legal capacity to decide)" is the choice of a Pregnant woman !!!

- "Gone are the days when it was thought that, on becoming pregnant, a woman lost, not only her capacity, but also her right to act as a genuinely autonomous human being."

- Its wrong to say that vaginal delivery is in some way morally preferable to a caesarean section: so much so that it justifies depriving the pregnant woman of the information needed for her to make a free choice in the matter."

b. NO Negligence if LSCS preferred over complicated Normal Delivery ...

- A case claiming compensation Rs. 20 lakhs+ against Doctors got rejected.
- The National Commission in its judgment dated 17th July, 2017, rejected the Complaint of Rs.20,27,350/-

**Case Details : KUNDAN LAL JAYASWAL & ANR V/s. DR. MALA PANDYA (THAKKAR) & ANR, Mumbai.**

**Facts :**

1. As per USG report dated 16.3.2015, there was a double loop of cord encircling about 2/3rd circumference around the neck of fetus. Her expected date of delivery was 23.04.2015. However on 25.3.2015, as the water discharge from uterus increased, the patient approached the Doctors and after other investigations, the Doctors decided to go for LSCS in the interest of patient.
2. On the same day at 9.45 PM, a male baby was delivered by LSCS.
3. It was alleged that the Doctors intentionally performed LSCS and the bill was inflated.

**Held :**

The National Commission dismissed the appeal after perusing the record and hearing the parties and held that as the double loop of cord was present around the neck of fetus, the emergency LSCS was performed. On the contrary, the Husband and the Relatives wanted to wait for the Normal Delivery ! Doctors cannot be always blamed, as some complications (like AFE in the present case) are unexpected, unavoidable and unpreventable. :

The judgment of NCDRC beings with following observation :

"The blame of tragic misfortune for unexpected, unavoidable, unpredictable, unpreventable Amniotic Fluid Embolism ( AFE), most of the times the obstetrician is a scapegoat. Unfortunately in some cases, despite the doctor's best intentions, patients suffer injury or die, and the clinicians involved often become the secondary victims."

**Case Details :**

**Dr. Manisha Agarwal, UP & anr V/s. Kapil Bajaj & anr.**

**First Appeal No.1107/2018, decided on 18th June, 2020.**

**III. Important Judgments on the POCSO Act (Implications for Doctors)**

1. X V/s. The Principal Secretary, Health and Family Welfare Department, Govt. of NCT of Delhi & Anr. Civil Appeal No 5802 of 2022 : Disclosing identity of the victim, a devil and deep blue sea situation for Doctors.

In this landmark judgment as we have seen in MTP Act section, the Apex court ruled in favour of harmonious interpretation of MTP and POCSO Act and held :

- a. Only on request of the minor and the guardian of the minor, need not disclose the identity and other personal details of the minor in the information provided under Section 19(1) of the POCSO Act.
- b. The RMP who has provided information under Section 19(1) of the POCSO Act (in reference to a minor seeking medical termination of a pregnancy under the MTP Act) is also exempt from disclosing the minor's identity in any criminal proceedings which may follow from the RMP's report under Section 19(1) of the POCSO Act.

Such an interpretation would prevent any conflict between the statutory obligation of the RMP to mandatorily report the offence under the POCSO Act and the rights of privacy and reproductive autonomy of the minor under Article 21 of the Constitution. It could not possibly be the legislature's intent to deprive minors of safe abortions.

This Judgment has given relief to RMPs from the harassment if they do not disclose the identity of the minor.

**2. "Mechanically Implicating Doctor U/S 21 POCSO Act For Not Reporting Crime Against Minor" is Absolute Injustice, Causes Mental Trauma: Hon. Kerala HC**

**CRL.MC NO. 4728 OF 2021, Dr.T.Ambujakshi v State of Kerala.**

Court added, "As a natural phenomenon when a patient meets a doctor, the doctor would act upon the age disclosed by her and no rowing enquiry in this regard is mandated by law.... Fastening criminal liability under Section 21 of the POCSO Act r/w Section 19(1) cannot be based on irrelevant materials and subsequent facts brought into, for which the accused has no nexus... There is no need to scabble about the age rather than believing it for the purpose of proceeding further."

3. Mere likelihood of suspicion was not sufficient but there must be grave suspicion that doctors knowingly failed to report about POCSO offence

**Tessy Jose & Ors. v. State of Kerala : CRIMINAL APPEAL NO(S). 961 OF 2018, Before hon'ble supreme Court.**

**Facts :** In this case, the victim was in advance stage of pregnancy. In fact, soon after she was brought to the hospital, she went into labour. She delivered the child and the Appellants are concerned, their role is that they attended to the victim.

In this case Two Senior Doctors and hospital Admin. Challenged the FIR wherein they were made the accused for not informing the alleged POCSO case to Police. Appellant no. 1 was a 66 years' Gynecologist and had conducted the delivery. Appellant no. 2 was a Paediatrician who had attended to the baby of the victim after the delivery. Appellant no. 3, was a 69 years' old Hospital Administrative and she was roped-in that capacity though she did not even attend to the victim or the baby.

The Apex court observed that in the given circumstances when the victim, it was even the professional duty of Appellant No. 1 to attend to her and conduct the delivery, which she did. Likewise, after the baby was born, the Appellant No. 2 as a Paediatrician performed her professional duty.

It was held by Hon'ble Apex Court that : mere likelihood of suspicion was not sufficient but there must be grave suspicion that doctors knowingly failed to report about POCSO offence. In that case, the Apex Court acquitted doctors who were accused of committing offence under Section 19 of the POCSO Act by stating that it was not their obligation to investigate and gather knowledge regarding the age of the victim.

#### **IV. Important Judgments on the PCPNDT Act**

The PCPNDT Act holds strict compliance requirements for all doctors performing ultrasound, genetic counseling, or prenatal tests. Courts have upheld a zero-tolerance policy.

1. The action (of seizure) without supporting reasons is lifeless, cannot sustain : The Action of Seizure of Hospital Struck Down by Hon. A.P. High Court. -

Case Details :

Raksha Hospital, Kurnool Dist. V/s. The State of A.P. & ors. (W.P. no. 27153/2025 , decided on 13/10/2025)

2. "Even without harassing Doctors, the aims and objects of PCPNDT Act can be achieved."

"The Complaint was filed after 3 years of the alleged incident, speaks volumes "

**Hon. Bombay High Court : CRIMINAL APPLICATION NO. 399 OF 2022 Chandrashekhar M. Gattani V/s. State of Maharashtra and anr.**

3. Mere Pendency of a criminal case is not a ground to refuse the renewal of registration –

**Case Details : CIVIL WRIT PETITION NO.9312 OF**

**2020. Hon. P&H High Court, at Chandigarh**

**Dr. Sanjiv Kaushal V/s. State of Haryana and others**

4. A Medical Geneticist as defined in the Act is exempted from any training under the 2014 Rules nor is

required to qualify the competency based assessment, A Doctor having experience of two years or more in the field Pre-natal Diagnostic Techniques falls within the definition of "Medical Geneticist"

**Hon'ble HIGH COURT OF JAMMU & KASHMIR AND LADAKH AT JAMMU, Case Details : WP(C)**

**No.2199/2022**

**Dr. Kuldeep Chander Sharma V/s. Union of India.**

5. "It's not an offense under the PCPNDT Act, if the computer generated reports like 'F Forms' are signed by the owner of the Hospital, instead of the concerned Sonologist/ Radiologist" -

Also held :

"Rightful delegation of Power to AA was upheld"

Case Details : APPROPRIATE AUTHORITY UNDER THE PCPNDT ACT, PIMPRI CHINCHWAD MUNICIPAL CORPORATION , Maharashtra V/s. DR. RAJENDER AMIRCHAND SUJANYAL & ORS, Criminal Appeal No.38/2022. – Hon'ble Supreme Court.

**6. Sonography Machines cannot be sealed, if registration renewal is pending :**

Hon. Bombay High Court. : Dr. Ramesh Bole V/s. State of Maharashtra (WRIT PETITION NO.4765 OF 2019), decided on 16/04/2019

The applicability of these judgments will always depend upon facts and evidences in each case. The Medicos should keep in mind the three ingredients of medical negligence are a duty of care owed by the medical professional to the patient, a breach of that duty (a failure to meet the standard of care), and damages suffered by the patient as a direct result of the breach. Only if these 3 ingredients are proved, a Doctor can be medically held negligent.



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## INDIA MTP Amendment Act (2021)

Medical termination of pregnancy is governed by the MTP Act, which was first enacted in 1971. The new Medical Termination of Pregnancy (Amendment) Act 2021 expands access to safe and legal abortion services on therapeutic, eugenic, humanitarian and social grounds to ensure universal access to comprehensive care.

The main purpose of this article is to provide a comprehensive overview of the amended MTP Act 2021. MTP Act clearly defines who (can do MTP), when (indications), where (place) and documentation.

### Who Should Do MTP– Person's Eligibility

RMP means practitioner with a recognized MBBS/PG degree or diploma (as defined in the Indian Medical Council Act, 1956) and the name has been entered in a state medical register

- RMP with a PG degree or diploma in obstetrics and gynecology can do MTP at any POG
- RMP–MBBS doctor can do MTP after specific training under following conditions:
  - o MTP up to 9 weeks by medical method only- experience of 3mnths in obgy at any hospital or independently done 10cases of MTP by MMA under supervision of an RMP at Govt hospital or pvt hospital approved by Gov
  - o MTP upto 12weeks by medical/surgical method- has assisted 25 cases of MTP of which at least 5 are done independently in hospital established and maintained by Gov or Centre approved by Gov
  - o MTP upto or beyond 24weeks \_ one year experience in OBGY or 6mnths house post in OBGY

### Who should Give an Opinion on MTP

- MTP <20 weeks- 1 RMP opinion
- MTP between 20 and 24 weeks– not less than 2 RMP opinion
- Beyond 24 weeks– medical board decision [Note: After 24 weeks two RMPs should perform the MTP]
- To save the life of the mother, MTP can be done at any place and the opinion of two RMPs is not applicable
- Medical Board members are gynecologist's,

pediatrician's, radiologists, and any other members as notified by the government.

### Functions and powers of the medical board in medical termination of pregnancy

#### Functions of the Medical Board Powers

- To examine the woman and her reports
- To provide the opinion of the Medical Board in Form D (rejection or approval) within 3 days of receiving the request for MTP To ensure that MTP, when advised by the Medical Board, is carried out with all safety precautions along with appropriate counselling within 5 days of the receipt of the request

- To ensure that MTP, when advised by the Medical Board, is carried out with all safety precautions along with appropriate counselling within 5 days of the receipt of the request
- #### Powers of the Medical Board

- To allow or deny MTP beyond 24 weeks gestation, only after due consideration and ensuring that the procedure would be safe for the woman at that period of gestation (POG) and whether fetal malformation has a substantial risk of being incompatible with life or if the child born may suffer from serious physical or mental abnormalities.
- To co-opt other specialists in the Board and ask for any additional investigations, if required, to decide on MTP.

Medical Board Details the procedures for evaluation, decision-making, and safety measures to ensure the woman's and the fetus's well-being.

### Indications for Medical Termination of Pregnancy (MTP) as per Amendments 2021

#### Up to 20 Weeks

- To save the life of the mother
- To prevent grave physical or mental injury to the mother
- Risk of physical or mental congenital abnormalities in the baby
- Humanitarian grounds: In cases of rape
- Contraceptive failure (both for married and unmarried women)

#### 20–24 Weeks

- Survivors of sexual assault, rape, or incest
- Minors (unmarried women)
- Change of marital status during pregnancy

(e.g., widowhood or divorce)

- Women with physical disabilities (major disability as defined under the Rights of Persons with Disabilities Act, 2016 [49 of 2016])
- Mentally ill women, including those with mental retardation
- Fetal malformation that has a substantial risk of being incompatible with life, or if the child born may suffer from physical or mental abnormalities resulting in serious disability
- Women in humanitarian settings, or those in disasters or emergency situations as declared by the government

#### **Beyond 24 Weeks**

##### **Fetal malformations only:**

- Incompatible with life or associated with physical or mental abnormalities that could lead to serious handicaps after birth
- MTP beyond 24 weeks can only be performed after due consideration of the risks to the woman and ensuring that the procedure will be safe for her at that stage of pregnancy.
- There is no upper limit for performing MTP beyond 24 weeks, but it is at the discretion of the Medical Board. Note: Any case requiring MTP beyond 24 weeks (e.g. in cases of rape) must be processed through a writ petition, as no other legal recourse exists beyond this gestational limit.

#### **What are the Exceptions?**

The modified act also authorizes one certified medical practitioner to perform an abortion at any stage of pregnancy if it is urgently required to preserve the pregnant woman's life, regardless of any of the aforementioned restrictions.

#### **Where MTP Should Be Done—Place**

- Hospital established or maintained by the government (no separate registration needed)
- PHC— up to 8 weeks
- CHC— up to 12 weeks
- District hospital— up to 24 weeks
- Medical college - any POG (up to 24 weeks and beyond)
- Private health facility which are approved by the government, i.e. district-level committee (DLC)

Note: For MTP up to 9 weeks, MMA drugs can be prescribed by a RMP at their clinic, provided such a RMP has access to a place which is approved for MTP (under Section 4 of the MTP Act, 1971 read with MTP Amendment Act, 2002 and Rules 5 of

the MTP Rules) and should display a certificate to this effect from the owner of the approved place.

#### **DOCUMENTATIONS**

It is mandatory to fill Form C, Form I or E or D, and Form III in all the cases, whenever MTP of a normally localized and live pregnancy is done. Forms need not be filled in cases of ectopic pregnancy, missed, incomplete abortion, fetal reduction, etc. Record all the information in the following forms, irrespective of the technique of abortion, i.e. MMA or surgical and also irrespective of any trimester.

Form II is the monthly reporting form, all the MTPs done in the previous month must be entered and it should be submitted to the district authorities within 1st week of every month.

#### **Key Features of the MTP Act Amendment, 2021**

The Medical Termination of Pregnancy (MTP) Act Amendment, 2021 expands access to safe abortion services for women facing unplanned pregnancies, addressing several critical issues. Key provisions of the amendment are shown in table Under the 2021 amendments, women are entitled to abortion up to 24 weeks of pregnancy in certain categories.

The law also allows abortion for contraceptive failure up to 20 weeks, a significant shift from the previous law, which only applied to married women. Now, any woman and her partner can access abortion due to contraceptive failure, including unmarried women in relationships.

Additionally, medical boards are now empowered to decide on abortions beyond 24 weeks under specific circumstances. These boards will consist of approved medical professionals who can grant or deny abortion requests based on established criteria.

#### **Changes in the Medical Abortion Timeline**

The amendment also increases the timeline for medical abortions from 7 weeks to 9 weeks of gestation. This allows for the use of medication abortion (also called medical consent abortion) by women up to 9 weeks of pregnancy, under the supervision of a registered medical practitioner (RMP).

**Significance:** The new law will contribute towards ending preventable maternal

## Comparison

Pregnancy Period	MTP Act 1971	MTP (Amended) Bill, 2021
Up to 12 Weeks	Advice of One doctor	Advice of One doctor
12 to 20 Weeks	Advice of Two doctors	Advice of One doctor
20 to 24 Weeks	Not allowed	Two Doctors for some categories (Given in form E ..consent of this category) of pregnant women
More than 24 Weeks	Not allowed	Medical Board in Case of Substantial Foetal Abnormalities
Any Time during Pregnancy	One Doctor, if immediately to Save Pregnant Woman's life.	One Doctor, if immediately to Save Pregnant Woman's life.

mortality to help meet the sustainable development goals (SDGs) 3.1, 3.7 and 5.6. SDG 3.1 pertains to reducing the maternal mortality ratio whereas SDGs 3.7 and 5.6 relate to universal access to sexual and reproductive health and rights. The amendments will increase the ambit and access of women to safe abortion services and will ensure dignity, autonomy, confidentiality and justice for women who need to terminate pregnancy.

### Analysis of the MTP Amendment

While the 2021 MTP Amendment brings significant improvements in expanding access to abortion services, it still presents certain challenges and limitations:

- Continued legal restrictions: The amendment maintains the restrictive nature of the original MTP Act, which was primarily designed to protect women from criminal prosecution rather than guarantee their full reproductive rights.
- Contradictions with international standards: The United Nations recommended that all states should ensure access to abortion without restrictions.
- Barriers in other legislation: Provisions such as those in the Protection of Children from Sexual Offences Act (POCSO) create additional barriers to safe and legal abortions, especially in cases involving minors.
- Disability-based eugenics: The inclusion of foetal mal-

formation as a basis for abortion after 24 weeks has been criticized for aligning with eugenic principles.

- Medical board oversight: The introduction of medical boards to approve abortions beyond 24 weeks adds another layer of bureaucracy and can become a significant barrier.
- Self-managed abortion: The law still restricts the ability of women to access abortion services autonomously, limiting the use of self-managed abortion methods.

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## Grey Areas of MTP act and Scope for Improvement

### INTRODUCTION

In the ever-evolving landscape of healthcare, the intersection of law and medicine has become increasingly significant. For Obstetricians and Gynaecologists, the complexity of legal obligations is amplified due to the intimate and critical nature of their work, which directly impacts the lives of women and their families. Among the key legislative frameworks governing their practice, the Consumer Protection Act, the MTP Act, the PCPNDT Act and the POCSO Act among various other acts, stand out as a pivotal.

This chapter delves into an overview of the provisions of MTP act, highlights the grey areas that create ambiguity, and explores the scope for reform.

### AMENDED MEDICAL TERMINATION OF PREGNANCY ACT, 2021

The MTP Act, enacted in 1971, aimed to reduce maternal mortality due to unsafe abortions by legalizing and regulating the process of medical termination of pregnancy under specific circumstances. The Act provided a legal framework for terminating pregnancies under specific indications, in regulated centres and performed by qualified Gynaecologists aiming to safeguard the health and well-being of women.

Over the years, societal attitudes, medical advancements, and growing recognition of women's reproductive rights have necessitated amendments to the law. The latest amendment, introduced in 2021, marks a significant progression by broadening the scope of legal abortion and addressing many of the limitations of the original Act. However, despite its advancements, the law continues to face practical challenges and ambiguities that affect its implementation.

This section explores the provisions of the MTP Act, with a focus on the 2021 amendments. It examines its progressive elements, identifies persisting grey areas, and discusses the scope for improvement to ensure that the law re-

mains responsive to the needs of modern medical practice and the rights of women. By critically analyzing these aspects, the aim is to provide insights into how the Act can be better aligned with the realities of healthcare delivery in India.

### Key Provisions of the amendments

- Enhanced gestational limits (24 weeks for certain categories).
- Inclusion of unmarried women for termination due to contraceptive failure.
- Role of the Medical Board for termination beyond 24 weeks.

Understanding the clarities and the grey Areas with suggestions for advocacy

### • MTP with medicines

o The amended act gave following clarities

- ♣ It is now allowed up to nine weeks
- ♣ It can be prescribed even in a clinic which is not a recognised centre under the act (however clinic has to display a certificate from any recognised centre to ensure that surgical completion of incomplete MTP can be done there)
- ♣ Even MBBS with training (10 cases under supervision of RMP or three months post in ObGyn hospital) can perform MTP with medicine

### o The grey areas are as follows

- ♣ Mechanism for submitting report (C,I,II,III) from the clinic is still not clear. Some local appropriate authorities do not accept reports from unrecognised clinic and owners of the attached recognised centres do not cooperate with the clinics in submitting the report through the centre.
- ♣ Drugs prescribed for MTP with medicine makes it obvious that MTP is being done. It becomes impossible to maintain confidentiality especially from the pharmacist, because writing the name of the patient on any prescription is legally mandatory
- ♣ It is not possible to fill form I within 3 hours because patient often aborts at home
- ♣ Admission register includes a column to enter titled "date of discharge". In MTP with medicine there is no admission; so, there can

be no discharge

**o Suggestions for advocacy:**

- ♣ Separate category for reporting of MTP with medicine
- ♣ Protection of RMP for confidentiality breach arising out of prescription
- ♣ Omit “date of discharge” from admission register for MTP with medicines
- MTP up to 20 weeks

**o The clarities after the amendment include following**

- ♣ Opinion of one RMP is enough
- ♣ Approval of centre criteria: Category A (MTP upto 12 weeks) remains the same while category B which were recognised for MTP up to 20 weeks have to be now read as ‘up to 24 weeks’
- ♣ Criteria for RMP: Those recognised for MTP upto 20 weeks will now be considered to be recognised for MTP up to 24 weeks
- ♣ Indication for MTP up to 20 weeks remain same as those mentioned in rules of 2003; however, after the amendment even an unmarried girl can now opt for MTP under the indication of ‘failure of contraception’.
- MTP for 20 - 24 weeks of gestation
  - o Clarities: Opinion of two RMPs is needed as per indications mentioned in the new form E
  - o Some grey areas in the indications (form E) deserves mention.
    - ♣ (a) Survivors of sexual assault or rape or incest
    - ♣ (b) Minors
    - ♣ (c) Change of marital status during the ongoing pregnancy (widowhood and divorce). There is no clarity about those cases where the divorce in process and not yet finalised
    - ♣ (d) Women with major physical disabilities as per criteria laid down under the Rights of Persons with Disabilities Act, 2016 (49 of 2016)
    - ♣ (e) Mentally ill women including mental retardation. Fortunately a psychiatry evaluation is not made mandatory.
    - ♣ (f) The foetal malformation that has substantial risk of being incompatible with life or if the child is born it may suffer from such physical or mental abnormalities to be seriously handicapped. It still does not address the challenge in justifying indication such Down syndrome or where one of the twin gestation fetus is having congenital anomalies and other is normal.
    - ♣ (g) Women with pregnancy in humanitarian settings or disaster or emergency situations as declared by Government. The term humanitarian settings need explanation
    - ♣ That single mothers are excluded from this list is a

grey area

- MTP beyond 24 weeks of gestation
  - o Clarity in amendment is as follows
    - ♣ MTP beyond 24 weeks is allowed only in case the fetus shows substantial congenital anomalies
    - ♣ Medical board (State Govt/UT ) will allow or deny permission within 3 days and two RMPs will have to perform the MTP within 5 days
    - ♣ Requirement of facility for beyond 24 weeks mentions “procedures under USG guidance”
  - o Grey areas
    - ♣ The State board which gives or denies permission to perform MTP beyond 24 weeks consist of members who are not Gynaecologist except one such member. Hence practically doctors who are not RMPs recognised under the act will give or deny permission to those who are RMPs under the act. Advocacy is needed to rectify this issue in formation of the State board
    - ♣ There are no guidelines to the board about which anomalies are included in “substantial anomalies”. So presently the permissions are given as per the whims and fancies of the board. Advocacy is needed to draft such a list
    - ♣ Time lines mentioned (e.g “permission within 3 days” and “termination within 5 days” does not clarify ‘within 3 or 5 days of which event’. Due to lack of such clarity, there can be delay in permission and performance of MTP. Advocacy is needed to get clarity of these timelines and proper provisions are made for the board members to be able to fulfil these duties within timeline while they also perform the other duties of their jobs.
    - ♣ Accessibility of State board remains a challenge for rural areas. Use of Teleconsultation with board should be looked in to.
    - ♣ Advocacy is needed to set up mechanisms to monitor compliance with the Act, particularly the functioning of Medical Boards. Penalties for unnecessary delays caused by administrative hurdles should be implemented.
    - ♣ If the baby born after termination delivers live; there can be ethical dilemmas if the parents refuse to accept the live born and also refuse to pay for NICU care. Advocacy is needed to frame rules about the procedure of termination (e.g use of intracardiac KCL) so that the baby born is not live. Legal responsibility for care in case the baby is born alive also needs to be defined
    - ♣ In some location the dead baby (often more than 500 gms in MTP beyond 24 weeks) is refused to be taken away for incineration by the biomedical waste disposal agencies. The hospital is left with no option but to dispose them as still born. This may unrec-

essarily lead to over reporting of still births and may badly reflect on the Obstetric care.

♣ Since no private hospital has license for MTP beyond 24 weeks, presently the only legal centre for such MTPs is a Govt hospital. State boards have the power to merely decide about indication for such MTP. The only legal entity which can allow any private centre to perform MTP beyond 24 weeks is a High Court. Advocacy is needed for giving such licenses for MTP beyond 24 weeks to private hospitals which have USG machine and are permitted under PCPNDT Act to perform intra-cardiac injection of drugs like KCL to the fetus.

• **Vague Definitions:**

o The definition of MTP mentioned in the act merely says; “termination of pregnancy by a procedure using medical or surgical method. It does not talk about intent of termination (which in case of MTP is to terminate life of the fetus). Hence induction of labour or elective LSCS can also be seen as MTP. It does not say that MTP is termination of a live pregnancy. Hence there remains a confusion of whether D&E /SE of missed abortion or termination of an IUFD etc is also within the ambit of MTP act. The definition does not talk whether MTP should terminate the pregnant state. This does not address the confusion of whether fetal reduction in a triplet pregnancy is MTP. Advocacy is needed to define MTP properly

• **Confidentiality issue:**

o After the amendment breach of confidentiality now attracts imprisonment of one year (section 5A i). In a hospital set up it is difficult to pin point the person who caused the breach and the RMP needs to be protected from being criminally implicated for a breach done by some staff.

o It is practically difficult to hide the procedure from the witness to the consent for the procedure being performed under anaesthesia.

o The amended act merely mentions that we are allowed to disclose the name of the woman to only ‘person authorised by law’. This is a very loose term as any Govt officer can claim himself/herself to be a ‘person authorised by law’. Advocacy is needed to clearly mention the list of persons for this purpose.

• **Inadequacy of form C:**

o Consent in form C is grossly inadequate because it does not follow the principles of consent taking given by the Supreme Court in the Sameera Kohli vs Prabha Manchanda case. The form C does not impart any ‘knowledge’ about MTP to the client. The author has drafted ‘information booklet’ of MTP along with two other authors. It is available as “Uniform FOGSI con-

sents” on the website [www.fogsi.org](http://www.fogsi.org).

• Pregnancies in adolescent girls under 18 yrs out of consensual sex.

o Pregnancies resulting from consensual adolescent relationships (POCSO context) are not explicitly addressed in the amended MTP act, leading to conflicts with the POCSO Act's reporting mandates.

o Harmonising the MTP Act with the POCSO Act to address issues of confidentiality and mandatory reporting in adolescent pregnancies is one more point for advocacy

• **LGBTQ and MTP act**

o Transgender and non-binary individuals requiring abortion are not explicitly mentioned. Provisions will have to be made soon.

**REFERENCES**

Primary Legal Texts

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o Text of the Act: Ministry of Law and Justice, India.

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**Blogs**

• [Indiankanoon.com](http://Indiankanoon.com)

• [Livelaw.com](http://Livelaw.com)

**Journals and Research Papers**

1. Indian Journal of Medical Ethics (IJME)

o Articles on MTP Act and its ethical implications.

2. The Journal of Obstetrics and Gynecology of India (FOGSI)

o Regular publications on legal challenges in obstetric practice.

3. International Journal of Gynecology and Obstetrics

o Comparative studies of Indian laws with international norms.

**Case Law Databases**

1. [Lawyerservices.in](http://Lawyerservices.in)

o Comprehensive repository of judgments under MTP, CPA, POCSO, and PCPNDT Acts.

2. India Kanoon (Free access)

o Searchable database of case laws across Indian courts



Dr Uma Wankhade

## Reproductive Rights in India: A Comprehensive Analysis of Legal Framework, Medical Imperatives, and Social Justice



Dr Swati Gurav

### Abstract

International human rights law defines reproductive rights as the right of all individuals to decide whether, when, and how many children to have, free from coercion, discrimination, and violence. Key components of reproductive rights include:

- The right to contraception and information.
- The right to decide whether to continue or terminate a pregnancy safely and legally.
- The right to safe pregnancy, childbirth and postpartum care.
- The right to access infertility and assisted reproduction technique without discrimination.
- The right to privacy, dignity in all these decisions.

### Medical and Public Health Imperatives

1) Maternal Mortality and Unsafe Abortion Globally, the maternal mortality ratio has decreased from approximately 328 deaths per 100,000 live births in 2000 to 197 in 2023, according to UNICEF data. Despite this progress, unsafe abortion remains a significant preventable cause of maternal death. The World Health Organization and Guttmacher Institute estimate that approximately 25 million unsafe abortions occur annually worldwide, representing roughly 45 percent of all abortions globally, with the majority occurring in developing countries. Complications arising from unsafe abortion contribute to approximately 13 percent of maternal deaths worldwide. From an obstetric and fetal medicine perspective, safe abortion services constitute standard, life-saving healthcare. As the World Health Organization explicitly states, abortion care represents healthcare, and

health constitutes a fundamental human right.

### 2.2 Contraception Access

The overall contraceptive prevalence rate increased from 54 percent to 67 percent between the National Family Health Survey-4 and NFHS-5. Contraception is a key part of reproductive rights—it's about having the freedom and access to choose how to prevent pregnancy.

Contraceptive choices include

- Barrier methods\* – condoms, diaphragms
- \*Hormonal\* – pills, patches, injections, implants
- \*IUDs\* – copper or hormonal
- \*Permanent\* – tubal ligation, vasectomy

Right to contraception empowers people to decide on family planning and spacing.

-Improves health outcomes by reducing unintended pregnancies and unsafe abortions

### 3. Social and human-rights :

Reproductive rights cannot be separated from gender inequality and the social hierarchy of socioeconomic class, rural–urban divide, disability and sexuality. National Family Health Survey data demonstrate that women who are poorer, less educated, and residing in rural areas experience higher unmet need for contraception forced pregnancy, forced sterilization . Frontline health workers including Accredited Social Health Activists and Auxiliary Nurse Midwives, transportation infrastructure, and respectful maternity care all constitute critical components of accessible reproductive healthcare.

Persistent stigma surrounding abortion, single motherhood, contraception for unmarried women, and infertility continues to push women into unsafe or exploitative situations. Furthermore, men's involvement in contracep-

tion and shared reproductive responsibility remains limited, with the burden falling disproportionately on women. Female sterilization remains the dominant modern contraceptive method throughout much of India, reflecting gendered patterns of reproductive responsibility.

#### **4. The Medical Termination of Pregnancy Act: Evolution Toward Rights-Based Care**

##### **4.1 Legal Framework and 2021 Amendments**

India's Medical Termination of Pregnancy Act of 1971, has 2021 Amendment, progressive amendment features are listed below.

Regarding gestational limits, termination is permissible up to 20 weeks on the opinion of one registered medical practitioner. For pregnancies between 20 and 24 weeks, termination is permissible for specific categories including survivors of rape or incest, minors, women with disabilities, and women experiencing change in marital status, based on the opinion of two registered medical practitioners. Beyond 24 weeks, termination is permitted only if a Medical Board diagnoses substantial fetal abnormality incompatible with life or causing serious handicap.

The recognized grounds for termination include risk to the pregnant woman's life, grave injury to her physical or mental health including pregnancy resulting from rape, and substantial risk of serious physical or mental abnormality in the fetus. Significantly, failure of contraception is recognized as a valid ground for both married and unmarried women following the 2021 amendment and 2022 Supreme Court interpretation. Section 5A of the Act prohibits disclosure of the woman's identity except to authorized persons, thereby protecting privacy and reducing stigma associated with abortion services.

##### **4.2 Constitutional Foundation: The 2022 Landmark Ruling**

In the case of X versus Principal Secretary, Health and Family Welfare Department, Government of NCT of Delhi (2022), the Supreme Court held that unmarried women possess the same right to abortion up to 24 weeks as married women, interpreting Rule 3B of the MTP Rules purposively. The Court emphasized that decisions to continue or terminate pregnancy are rooted in bodily autonomy and decisional privacy under Article 21 of the Constitution. Denying access based on marital status was deemed unconstitutional and based on patriarchal assumptions regarding permissible sexual activity.

##### **4.3 Implementation Challenges**

Despite progressive legal provisions, practical imple-

mentation remains uneven. Comprehensive Abortion Care guidelines note that many women continue resorting to unsafe abortions due to poor awareness of legal provisions, provider refusal, or absence of services at primary healthcare facilities.

#### **5. The PCPNDT Act: Balancing Anti-Discrimination and Healthcare Access**

India has historically faced severely skewed sex ratios resulting from son preference and sex-selective abortion. The Pre-Conception and Pre-Natal Diagnostic Techniques Act of 1994, amended in 2003, aims to prohibit sex selection before or after conception, regulate prenatal diagnostic techniques including ultrasound and amniocentesis to prevent misuse for sex determination, and mandate registration of all genetic counseling centers, laboratories, and clinics with strict record-keeping requirements.

Recent data indicate improvement in India's sex ratio at birth to 917 girls per 1000 boys for 2021-2023, with twelve states exceeding the national average. The government attributes this improvement partly to stricter PCPNDT implementation and broader gender equity programs. Specific districts such as Panchkula have reported improved sex ratios and reduced late-term terminations following intensive inspections of ultrasound and MTP centers with strict enforcement against violations.

##### **5.2 Navigating the Balance**

From a fetal medicine perspective, the PCPNDT Act proves vital for curtailing unethical sex selection. Excessive administrative requirements and fear of raids may make radiologists reluctant to provide services, thereby worsening diagnostic gaps particularly for economically disadvantaged women.

Healthcare providers must maintain impeccable PCPNDT records while explicitly counseling couples that sex determination is both illegal and refused, even as anomaly screening is encouraged.

#### **6. Assisted Reproductive Technology Regulation**

Infertility affects an estimated 10 to 15 percent of couples globally. Assisted reproductive technology including in vitro fertilization, intracytoplasmic sperm injection, donor gametes, and surrogacy has transformed reproductive possibilities while raising ethical, legal, and commercial concerns.

##### **6.1 The ART Regulation Act of 2021**

The Assisted Reproductive Technology Regulation Act of 2021 seeks to register all ART clinics and banks under a National Registry, establish standards for in-

rastructure, personnel, laboratory practices, and record-keeping, protect gamete donors, commissioning parents, and children through consent and confidentiality norms, prohibit sex-selective ART through explicit linkage with PCPNDT provisions, and limit age for access to women aged 21 to 50 years and men aged 21 to 55 years.

There is debate for ongoing IVF treatment, arguing that rigid age cutoffs violate the constitutional right to form a family.

## 6.2 Access and Justice Considerations

From a social justice perspective, three critical questions emerge. First, who can access ART? Current provisions favor heterosexual married couples, while single women and queer couples face greater barriers despite constitutional advances on equality and privacy. Second, who bears the risks? Economically disadvantaged women may be recruited as egg donors or surrogates. Strong regulation proves necessary to prevent coercion and exploitation, yet prohibitions without social security alternatives may simply drive practices underground. Third, how are children born via ART protected? The Act provides for parentage, citizenship, and children's rights, but implementation and awareness remain patchy.

Policy-makers should review age limits and marital status restrictions in light of evolving jurisprudence on privacy and equality.

## 7. Constitutional Foundation: Privacy and Reproductive Autonomy

The constitutional foundation has influenced the 2022 abortion ruling extending MTP protections to unmarried women and High Court decisions reiterating that making sexual and reproductive choices constitutes a fundamental right with the consent of the pregnant person paramount. For instance, the Madhya Pradesh High Court refused to order abortion without the minor rape survivor's consent, affirming individual autonomy.

The Puttaswamy judgment fundamentally shifts reproductive decision-making from matters solely of public policy or morality into the domain of individual rights, with the State bearing a duty to facilitate rather than control these choices.

## 8. Autonomy in Practice: Beyond Formal Legal Rights

### 8.1 Operationalizing Autonomy

Autonomy in reproductive health requires that women or pregnant persons choose if and when to conceive

through access to contraception, assisted reproduction, and information; decide whether to continue pregnancy within legal bounds without coercion by family, partners, or the State; and exercise informed consent in labor including mode of delivery, pain relief, and consent for procedures such as induction, episiotomy, or cesarean section.

From an obstetric perspective, respecting autonomy represents not merely legal obligation but sound medical practice. Shared decision-making improves treatment adherence, mental health outcomes, and clinical results.

## 9. Toward Integrated Rights-Based Implementation

Combining perspectives from obstetrics, fetal medicine, law, and social activism, a comprehensive rights-based reproductive health system for India would encompass several elements. First, ensuring universal access to quality maternal healthcare requires fully functional First Referral Units with cesarean and blood bank capacity in every district, with aggressive monitoring and support for vulnerable women in high-risk states and districts.

Second, normalizing contraception and sexuality education requires implementing family planning and comprehensive sex education, focusing on adolescents, men, and marginalized communities rather than solely postpartum women. Third, making safe abortion accessible beyond merely legal involves training MBBS physicians and mid-level providers in Comprehensive Abortion Care and medical abortion, ensuring MTP services at primary and community health centers with referral pathways for second-trimester care, and reducing stigma through public campaigns framing abortion as healthcare and a right rather than crime.

Fourth, intelligent PCPNDT implementation requires targeting sex determination networks rather than routine obstetric practice, linked with broader schemes encouraging girl child survival, education, and financial security. Fifth, ethical and inclusive ART regulation involves enforcing standards preventing exploitation of donors and surrogates while re-examining age and marital status restrictions in light of constitutional principles ensuring non-discrimination.

Finally, grounding everything in autonomy and consent requires institutionalizing informed consent forms and counseling protocols in local languages, and auditing institutions not merely for equipment but for respectful maternity care and freedom from abuse and coercion.

### 10. Conclusion

India's legal framework governing reproductive rights is, in many respects, more progressive on paper than frameworks in several high-income countries currently rolling back abortion rights. The Medical Termination of Pregnancy Amendments, PCPNDT Act, and Assisted Reproductive Technology Regulation Act together attempt balancing women's autonomy, fetal interests, gender justice, and ethical medical practice.

For clinicians, lawyers, activists, and policy-makers, the real task remains practical: translating rights into reality for every woman—rural or urban, wealthy or poor, married or unmarried—so that reproductive health represents not privilege but lived human right. This requires sustained commitment to infrastructure development, provider training, community education, stigma reduction, and vigilant protection of autonomy against paternalistic interference from family, community, or state actors. Only through such comprehensive, multi-sectoral efforts can India's progressive legal framework translate into meaningful reproductive justice for all.

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Dr Suresh Doshi

## Confidentiality Under MTP Act : Ensuring Privacy For Woman And Implications Of Any Breaches

### INTRODUCTION:

The MTP ACT was passed in 1971 and came into force from 1st April 1972.

RULES AND REGULATIONS were formulated in 1975 and were amended 1st in 2003 and them from time to time.

Medical termination of pregnancy regulations, 2003 gives following regulations for confidentiality

Custody of forms, -

(1) The consent given by a pregnant woman for the termination of her pregnancy, together with the certified opinion recorded under section 3 or section 5, as the case may be and the intimation of termination of pregnancy shall be placed in an envelope which shall be sealed by the registered medical practitioner or

practitioners by whom such termination of pregnancy was performed and until that envelope is sent to the head of the hospital or owner of the approved place or the Chief Medical Officer of the State, it shall be kept in the safe custody of the concerned registered medical practitioner or practitioners, as the case may be.

(2) On every envelope referred to in sub-regulation (1), pertaining to the termination of pregnancy under section 3, there shall be noted the serial number assigned to the pregnant woman in the Admission Register and the name of the registered medical practitioner or practitioners by whom the pregnancy was terminated and such envelope shall be marked "SECRET".

(3) Every envelope referred to in sub-regulation

(2) shall be sent immediately after the termination of the pregnancy to the head of the hospital or owner of the approved place where the pregnancy was terminated.

(4) On receipt of the envelope referred to in sub-regulation (3), the head of the hospital or owner of the approved place shall arrange to keep the same in safe custody.

(5) Every head of the hospital or owner of the approved place shall send to the Chief Medical Officer of the State, IN form II a monthly statement of cases where medical termination of pregnancy has been done.

(6) On every envelope referred to in sub-regulation (1), pertaining to the termination of pregnancy under section 5, there shall be noted the name and address of the registered medical practitioner by whom the pregnancy was terminated and the date on which the pregnancy was terminated and such envelope shall be marked "SECRET"

#### **Maintenance of Admission Register, -**

(1) Every head of the hospital or owner of the approved place shall maintain a register in form III for recording there in the details of the admissions of women for the termination of their pregnancies and keep such register for a period of five years from the end of the calendar year it relates to.

(2) The entries in the Admission Register shall be made serially and a fresh serial shall be started at the commencement of each calendar year and the serial number of the particular year shall be distinguished from the serial number of other years by mentioning the year against the serial number, for example, serial number 5 of 1972 and serial number 5 of 1973 shall be mentioned as 5/1972 and 5/1973.

(3) Admission Register shall be a secret document and the information contained therein as to the name and other particulars of the pregnant woman shall not be disclosed to any person.

#### **Admission Register not to be open to inspection, -**

The Admission Register shall be kept in the safe custody of the head of the hospital or owner of the approved place, or by any person authorized by such head or owner and save as otherwise provided in sub-regulation (5) of regulation 4 shall not be open for inspection by any person except under the authority of law .

Provided that the registered medical practitioner on the application of an employed woman whose pregnancy has been terminated, grant a certificate for the purpose of enabling her to obtain leave from her employer ; Provided further that any such employer shall

not disclose this information to any

#### **The MTP ACT was amended in 2021 and the new rules came into force.**

Section 5 of the ACT is related to confidentiality of the procedure and the woman undergoing it.

Section 5 (A) was included in the ACT in 2021 which reads as follows.

"5A. (1) No registered medical practitioner shall reveal the name and other particulars of a woman whose pregnancy has been terminated under this Act except to a person authorized by any law for the time being in force.

(2)Whoever contravenes the provisions of sub-section (1) shall be punishable with imprisonment which may extend to one year, or with fine, or with both.

While practicing MTP in day-to-day practice following points are to be considered by the RMP providing MTP Services.

The name/ identity of the person undergoing MTP shall be mentioned on only registered maintained in form III under the ACT.

It means the name/identity of patient can not be revealed on indoor papers, discharge cards or any other documents. For this purpose the patient should be identified on all hospital documents by the admission number given in mtp admission register IN FORM III as specified in mtp rules and regulations.

For eg if patients name is mrs xyz and her mtp admission register number is MTP NO 25/2025 then everywhere in hospital documents the patients name will come as

MTP no 25/2025 and not as mrs xyz.

#### **Situations which arise commonly are**

1)Patients wants bills, receipts and discharge cards for insurance purposes.

The patient should be made aware that she will get the documents not in her name but as as per her MTP number in the MTP admission register.

2)Patient wants certificate for leave.Then you can take an application about the same and give certificate for the leave.

3)Conflict with POCSO ACT

IF THE patient is minor and her pregnancy is out of consensual sex, the patient and her legal gaurdians agree that they want termination then the RMP is in a fix because there is conflict between two statutes.

MTP act asks to maintain confidentiality ,where as POCSO makes it compulsory reporting under sec 19.

To our rescue in such cases Supreme court guidelines given in 2022 come to our help (civil appeal no 5802 /2022 , x verses principal secretary family welfare de-

partment of government of nct of delhi) .following are the guidelines

To ensure that the benefit of Rule 3B(b) is extended to all women under 18 years of age who engage in consensual sexual activity, it is necessary to harmoniously read both the POCSO Act and the MTP Act. For the limited purposes of providing medical termination of pregnancy in terms of the MTP Act, we clarify that the RMP, only on request of the minor and the guardian of the minor, need not disclose the identity and other personal details of the minor in the information provided under Section 19(1) of the POCSO Act. The RMP who has provided information under Section 19(1) of the POCSO Act (in reference to a minor seeking medical termination of a pregnancy under the MTP Act) is also exempt from disclosing the minor's identity in any criminal proceedings which may follow from the RMP's

report under Section 19(1) of the POCSO Act. Such an interpretation would prevent any conflict between the statutory obligation of the RMP to mandatorily report the offence under the POCSO Act and the rights of privacy and reproductive autonomy of the minor under Article 21 of the Constitution. It could not possibly be the legislature's intent to deprive minors of safe abortions.

#### References

- 1)MTP ACT 1971
- 2)MTP RULES 2003
- 3)MTP REGULATIONS 2003
- 4)MTP ACT 2021
- 5)SUPREME COURT OF INDIA civil appeal no 5802 /2022 , x verses principal secretary family welfare department of government of nct of delhi)



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## Legal and Social perspective

(Addressing inclusion of unmarried women and the shift from 'Husband' to 'Partner' in the MTP Act.)

Enactment of MTP Act 1971 was one of the landmarks in the legal history of India since it made termination of pregnancy legal and voluntary. The unique feature of the Act was 'Failure of contraception' as an indication for termination. It allowed almost any woman with unintended pregnancy, the freedom to terminate pregnancy. The indication, however allowed only married women to exercise this option. It took some Supreme court judgments, changing social contexts, persuasion by social and academic organizations, that the law makers decided to amend the Act in 2021, almost 50 years after its enactment. Few amendments were added to the rules in 2003 which were regarding experience and qualification of RMP and also regarding premises where MTP is to be performed. 2003 amendment also included medical method of abortion using RU-486 along with misoprostol.

In MTP Act 1971, Ss 3 (ii) Explanation 2 says -- 'Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the

mental health of the pregnant woman.'

This clearly prohibited termination of unmarried woman or a woman in living relationship for the indication of failure of contraception. However grave injury to the mental health could be used as an indication in case of unmarried woman. This ambiguity was removed by the 2021 amendment.

#### Key changes to the MTP Amendment Act - 2021 are

1. Replacing 'married woman or husband' with "any woman or her partner".
2. Extending legal access to abortion from 20 weeks to 24 weeks, and more than 24 weeks subject to approval by medical board/courts.
3. Opinion of one RMP up to 20 weeks and two RMPs from 20-24 weeks termination.

The amendment was perceived very well by medical field as well as by society as it removes many hurdles for both doctors and women and the legal field welcome it as a pragmatic amendment with simplification.

There are still some grey areas in the Act that concern mainly the medical fraternity which will be discussed later in the chapter.

## Social perspective –

### 1. Recognition of Reproductive Autonomy as a Fundamental Right

By replacing ‘unmarried women and partner’ as the indication of MTP in place of ‘married woman or husband’ in the indication ‘Failure of contraception’, The law affirms that bodily autonomy is not dependent on marital status, and It aligns with Article 21 of the Constitution which assures personal liberty, privacy, and dignity. Thus sending a clear social message that – An unmarried woman has the same reproductive rights as a married woman.

This reduces institutional discrimination in healthcare settings.

### 2. Knocking off Social Stigma and Moral Policing

- Challenging social norms around sexuality

Indian society has historically been judgemental about premarital sexual activity, living in relationship and consensual sex, wherein such behaviour is looked down upon as immoral. Pregnancy out of such relationship creates monumental problems particularly for an unmarried woman. The amendment in the Act thus:

- Normalises the idea that not all pregnancies occur within marriage.
  - Shields the women from moral policing by families, doctors, and institutions.
  - Diminishes the patriarchal notions of the society towards “legitimate” and “illegitimate” motherhood.
  - Encouraging women to seek safe medical care
- Fear of being judged immoral, an unmarried women may tend to seek unsafe abortions methods from an unqualified provider or may attempt chemical self-abortion. This jeopardises the health of such women. Legal inclusion thus reduces stigma and increases safe health seeking behaviour.

### 3. Public Health and Safety Considerations

- Access to Safe Abortions

WHO recognises unsafe abortion as a leading cause of maternal mortality. Though significantly reduced, this still is a harsh reality in India. For an unmarried woman, these barriers are bigger because of label of immorality needed secrecy . Legal inclusion ensures timely access to certified facilities thus reducing unsafe abortions and ultimately improved maternal health outcomes.

- Confidentiality

Breach of identity or privacy is the biggest concern for an unmarried woman. The MTP provisions support utmost confidentiality, which is essential in preventing psychological distress, avoiding coercion and subjugation by family thus protecting woman from honour based violence.

### 4. Socio-Economic Dimensions

- Preventing educational and career disruption

In a country like India, where more and more women are now shoulder to shoulder with men in every sphere of society, be it work, education or profession, unintended pregnancies disproportionately impact woman’s education, employment prospects and financial independence in general and unmarried woman in particular.

Access to legal abortion helps prevent such lifelong socio-economic disadvantages.

- Avoiding forced marriages or social ostracization

Historically and in moral ambit of Indian society, pregnancy in unmarried woman leads to undesired or forced marriage, abandonment by the family or social isolation. Allowing MTP in an unmarried woman thus provides an alternative that respects a woman’s life path.

### 5. Protection Against Gender-Based Violence

Victimhood of a woman and unintended pregnancy are usually out of sexual relations that are diverse. It may result from: consensual premarital sex, deceptive relationships, coercion, abuse, or rape. This legal provision thus allows relief without requiring a woman to justify her personal circumstances in moral terms. It also supports survivors of the sexual assault as it no longer forces unmarried women to fit their case into narrow categories. It respects their vulnerability and recognises their rights.

### 6. Changing Cultural and Legal Narratives of Family and Sexuality

The traditions in the Indian society and prevalent Indian legal framework assumed that reproduction can only be within marriage. The amended MTP Act approach acknowledges the changing social realities, and endorses diverse family structures and relationships in the fast-changing fabric of the society by moving away from marriage centric reproductive laws. It further supports and aligns India with global human rights norms that view reproductive choice as a basic human right. Key Case Laws and Their Medico-Legal Implications X vs Principal Secretary, Health & Family Welfare Department, Govt. of NCT Delhi (2022,SC)

#### The Supreme Court held:

**“The marital status of a woman cannot determine her right to access abortion.”**

#### Key Directions

1. Unmarried women are eligible for termination up to 24 weeks in the same way as married women.
2. Failure of contraception in live-in or non-marital relationships is legally valid.

3. The expression "partner" is not confined to marriage.

4. Ensuring access to safe abortion is part of Article 21 rights.

#### **Medico-Legal Significance**

- Doctors cannot deny services due to unmarried status.
- Ethical bias or refusal may constitute violations of reproductive rights.
- Expands permissible grounds for termination after 20 weeks.

#### **Suchita Srivastava v. Chandigarh Administration (2009, SC)**

**Held :** Reproductive autonomy is a fundamental right under Article 21.

#### **Relevance**

Asserts that autonomy applies to all women, irrespective of marital status.

Clinicians must respect informed consent and avoid paternalistic attitudes.

Justice K.S. Puttaswamy v. Union of India (2017, SC)

Right to privacy includes bodily integrity and resolute autonomy.

#### **Relevance**

Disclosure of an unmarried woman's abortion details without consent, violates right to privacy which is bestowed constitutionally.

#### **ABC v. Union of India (2020–2022, Delhi HC & SC Review)**

Unmarried women sought termination beyond permissible limits due to socio-economic circumstances.

#### **Judicial View**

Recognised that unintended pregnancies among unmarried women cause significant mental anguish.

#### **Relevance**

Supports liberal interpretation of "grave injury to mental health."

#### **Rape and Unmarried Women Cases**

Multiple High Court cases (e.g., Chaitra v. State of Karnataka, XYZ v. State of West Bengal) have allowed termination in unmarried minors or adults impregnated due to:

- sexual assault,
- deception in relationships,
- coercion.

#### **Medico-Legal Impact**

- Doctors must be aware of the expanded interpreta-

tion of mental health injury.

- Delays due to court referrals can cause negligence claims—timely referral is essential.

Responsibilities and Legal Duties of impact on medical profession.

Consent - Only the woman's consent is required if she is an adult.

For unmarried minors (<18) or mentally ill women, guardian consent is needed

Gestational Age and Compliance - Doctors must follow 20-week and 24-week guidelines, approach Medical Boards where required, document indications appropriately.

Failure to adhere exposes practitioners to - civil liability, criminal complaints or professional misconduct allegations.

#### **Documentation Requirements**

- Mandatory - Form C (consent), Form I (opinion of RMP), Form II & III (facility records),
- strict confidentiality maintenance.

Improper documentation is a common ground for medico-legal action.

#### **Denial of Services**

- Unmarried status cannot be a reason for refusal.
- Wrongful refusal can lead to - constitutional claims, complaints to medical councils, negligence suits if harm results.

#### **Persistent and prevalent Challenges**

- Healthcare providers may lack awareness or act in a discriminatory manner, inhibiting access to safe abortions for unmarried women or couple in living relationship.

- Practical barriers, such as lack of privacy, confidentiality, and fear of breach of anonymity, still turn away many unmarried women from seeking safe medical help.

- Relentless advocacy and public education are required to align social norms with the evolving legal framework.

Many pragmatic and landmark Supreme Court rulings affirm equal abortion rights for unmarried women but several grey areas and hurdles still persist.

#### **Grey areas after the amendment.**

- While court rulings mandate non-discrimination based on marital status, the Medical Termination of Pregnancy (MTP) Act and Rules still create uncertainty in eligibility and categories, often leaving interpretation to individual providers or judges. This ambiguity

needs to be addressed.

- The law continues to emphasize provider discretion and approval (especially for abortions beyond 20 or 24 weeks), making access inconsistent and sometimes contingent on the biases or values of medical boards or doctors rather than the woman's autonomy.
- Post-24-Week Pregnancies: Abortions after 24 weeks remain permitted only in very narrow cases (severe fetal abnormalities or threats to the woman's life), requiring medical board approvals, and mental health justifications are considered only under specific, restrictive situations.
- Regional and Judicial Variability: Some high courts interpret the law restrictively, leading to a patchwork of decisions and inconsistent access depending on location and the specifics of each case.
- Pregnant women and particularly unmarried women or women in living in relationship may be deterred due to inadequate healthcare infrastructure, lack of awareness among providers, social stigma, and inadequate enforcement of confidentiality which are still persistent.
- For medical professionals ambiguity about reporting Medical abortions is not addressed.

## Summary

In sum, while the law now affirms the right of unmarried women to safe and legal abortion, meaningful change also requires shifts in societal attitudes, greater awareness among healthcare professionals, and systemic efforts to protect woman's autonomy and dignity.

While the Supreme Court's rulings have advanced rights for unmarried women, full, effective, and uniform access to safe abortion still requires further legal reform, consistent implementation, recognition of all gender identities, and stronger safeguards for women's autonomy nationwide.

## 7. Conclusion

The inclusion of unmarried women and replacing husband with partner within the MTP Act framework, clarified legislatively in 2021 and judicially through the landmark 2022 Supreme Court decision, reflects a significant evolution in India's medico-legal approach to reproductive rights.

Thus it

- affirms equality and autonomy,
- ensures non-discriminatory healthcare provision,
- reduces medico-legal risk for doctors,
- aligns with constitutional principles of dignity and pri-

vacy.

For medical practitioners, the key takeaway is clear: "Abortion is a legal, ethical, and constitutional right for any woman, not only married women."

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## The intersection of Reproductive rights and gender equality examining the broader social and legal impacts of MTP law on women health & autonomy

### FACTS –

1] Article 21 -Protection of life and Personal Liberty – “No person shall be deprived of his life or personal liberty except according to procedure established by law”. Article 21 of the Indian Constitution guarantees the fundamental right to protection of life and personal liberty. It ensures certain safeguards against arbitrary deprivation of life and liberty.<sup>[1]</sup>

2] Reproductive health has been defined as “the capability to reproduce and the freedom to make informed, free and responsible decisions. It also includes access to a range of reproductive health information, goods, facilities and services to enable individuals to make informed, free and responsible decisions about their reproductive behavior”<sup>[2]</sup>

3] Reproduction rights - The World Health Organization (WHO) specifies that “Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health”<sup>[2]</sup>

4] ABORTION law in INDIA - THE BHARATIYA NYAYA SANHITA, 2023 NO. 45 OF 2023 section 88,89,90,91,92 [ formerly IPC section 313, 314, 315 and 316, 1860] contain provisions for punishment in case of abortion and miscarriage which is done with the intention of causing death of the unborn child. Thus, not only is full autonomy not provided in case of abortion in India but it is also made a cognizable offence under the IPC. This implies that abortion in India is only legal if done in good faith for medical purposes. So MTP act 1972 allows legal abortion in India.<sup>[3]</sup>

5] MTP ACT – In simple terms – abortion in India depends on the opinion of a Registered Medical Practitioner (RMP) or DOCTORS OPINION . RMP having right to do termination of pregnancy on

women’s (or guardian) request and consent at approved place & with in prescribed gestational & indication. Therefore abortion is not fully pregnant women right regarding her abortion.<sup>[4]</sup>

6]MTP ACT AMMENDMENT - Its allow termination of pregnancy till 24 wks for specific indications and beyond 24 wks for sever fetal malformation by medial board opinion. This expands reproductive rights certain categories of women including survivors of rape, incest, minor, unmarried women, mental illness, widows & divorced women.<sup>[5]</sup>

7] Public health data- The Maternal Mortality Ratio (MMR) for India is 97/100,000 live births (RGI-SRS: 2018-20) and unsafe abortions account for 8% of the MMR. Many of those who survive these clandestine procedures often suffer from chronic, debilitating diseases that have a bearing on the future reproductive health of the woman.

### Discussion –

The World Health Organisation (WHO) specifies that “Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.”<sup>[3]</sup>

Reproductive autonomy encompasses several critical areas:

**Decision-Making Power:** The ability to decide, freely and responsibly, the number, spacing, and timing of children. This includes choosing whether to procreate or abstain from procreating.

**Access to Healthcare:** Entitlement to comprehensive sexual and reproductive healthcare services, information, and education, including contraception, safe abortion, maternal care, and prevention of sexually transmitted infections.

**Bodily Integrity:** Freedom from all forms of reproductive coercion, violence, and non-consensual

sual medical interventions, such as forced sterilization or forced pregnancy.

**Equality and Non-discrimination:** The right to access services and make decisions irrespective of marital status, age, socioeconomic background, race, or sexual orientation.

Supreme Court Recognition of Reproductive Autonomy. In *Devika Biswas v. Union of India & Ors.*<sup>[7]</sup> Which surpassed the reproductive health framework and also realized autonomy and gender equality as a part of women's constitutionally protected reproductive rights. Speaking for the bench, Justice Chandrachud noted, "A changed social context demands a readjustment of our laws. Law must not remain static and its interpretation should keep in mind the changing social context and advance the cause of social justice". The Court held that every pregnant person in India has a right to reproductive decisional autonomy, including transgender and gender-variant persons. Everyone is entitled to reproductive health, including access to safe, effective, and affordable methods of family planning, access to contraception, and sex education. Further, the Court acknowledged that the MTP Act is a provider-centric law that does not focus on the rights of pregnant persons. Since the right to access abortion depends on approval from a RMP, denial of services compels women to approach courts or seek abortion in unsafe conditions. Rights in the reproductive are relatively new to India. Sometimes its look like the Medical Termination of Pregnancy Act, 1971 was motivated by fears about population growth in India and part of a host of measures (including forcible sterilization) targeted at reducing the population growth rate.

### **Challenges to Women's Reproductive Autonomy**

**Legal Restrictions:** Restrictive laws, especially concerning abortion, often force women to seek unsafe, clandestine procedures, which are a major cause of maternal mortality.

**Socioeconomic Factors:** Poverty, lack of education, and limited access to health system affect the ability of women from basic healthcare facilities.

**Patriarchal and Cultural Norms:** currently many regions of India reproductive decisions are made by partners or family members, rather than the woman herself.

**Political and Legal frameworks:** Political instability and conservative religious or cultural movements can affect reproductive rights, making them vulnerable to changing political climates.

### **The Importance of Autonomy**

The ability for a woman to control her own fertility and make autonomous choices about her body is fundamental to her dignity and personal liberty. Without this autonomy, women face significant risks to their physical

and mental health, educational opportunities, and economic participation. Upholding reproductive autonomy is key to empowering women and fostering a just, equitable society. The consequences of an unwanted pregnancy on a woman's body...cannot be understated. The fetus relies on the pregnant woman's body for sustenance and nourishment until it is born<sup>[12]</sup>. The biological process of pregnancy transforms the woman's body to permit this. The woman may experience swelling, body ache, contractions, morning sickness, and restricted mobility, to name a few of a host of side effects. Further, complications may arise which pose a risk to the life of the woman.

**Global Initiatives:** The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW): It is an international legal instrument that requires countries to eliminate discrimination against women and girls in all areas and promotes women's and girls' equal rights. The International Covenant on Civil and Political Rights (ICCPR): It aims to ensure the protection of civil and political rights National initiatives- In India, there is a lot of disagreement between pro-choice and pro-life views on abortion laws. Pro-choice views include a woman's right to choose whether to have an abortion, as well as the state's duty to protect every life<sup>[9]</sup>. Constitution-Bench decision of the Supreme Court in *KS Puttaswamy v UOI*<sup>[10]</sup> -it started new field of thinking about reproductive rights and women's autonomy in India, which the Act does not cover. In this case, the Supreme Court said that women have a constitutional right to make their own reproductive choices. They also said that the right to "abstain from procreating" was in line with the right to privacy, liberty, bodily autonomy, and dignity. It was J. Chandrachud who explained how access to contraceptive options and abortion important part of due process is. He also said that volitional autonomy for ending a pregnancy is a part of privacy. Privacy is a place where people can be alone, but they also have a lot of freedom. He said that an "unreasonable" restriction cannot be put on that freedom, and so it can only be allowed if it meets the constitutional standard of reasonableness. a major problem with this constitutional right is the poor state of the health infrastructure and a low literacy rate. These can be both illegal and dangerous, and the high rate of maternal deaths is proof of that. That is why, it is said, most women in India are forced to compromise their reproductive health because there is not enough health infrastructure.

With medical advancements, premature babies as early as 24-26 weeks can survive with intensive care. This raises concerns that should abortion rights be reduced as neonatal care improves? However, there is a risk of legal precedence restricting abortion rights based on

medical developments rather than reproductive autonomy. Medical boards follow strict guidelines, allowing abortion only in extreme cases. Women seeking abortions post-24 weeks face lengthy legal battles, delaying decisions. E.g., A woman with postpartum depression was denied abortion at 26 weeks despite medical complications.<sup>[11]</sup> The rights of a fetus under the Indian Constitution are unclear as there has been no upfront articulation of it. One of judgment judge b.v.Nagarathna stated It may not be out of place to note that a fetus is<sup>[12]</sup> dependent on the mother and cannot be recognized as an individual personality from that of the mother as its very existence is owed to the mother. It would be incongruous to conclude that the fetus has a separate identity from the mother and in spite of the physical or mental health of a mother being under threat; she will have to continue her pregnancy until the fetus is born which would endanger her delicate health

#### **Challenges faced by RMP in implementing MTP Acts**

- 1] Fear of legal prosecution -RMP performs selective MTP work due to fear of Police cases, investigations, court appearances, excessive documentation. It creates moral and legal dilemmas.
- 2] legal safety-RMP considers there legal safety while handling complicated cases. Investigation police officers, advocates, judges lack deep understanding of MTP act so RMP fills harassed by this legal systems .
- 3] Consideration of medical association - For making RMP friendly implementation of MTP ACT requires consideration of medical associations view while making law and guidelines.
- 4] Fraudulent patient -While considering women Autonomy by RMP they get bad experiences sometime with fraud patients. Some women give wrong or fake identity, age proof, marital status, clinical history, past history. Some women gives consent of abortion but in latter do police complaint if any dispute occurs with partner in relationship. So RMP denies cases if they feels any troublesome in cases.
- 5] Weak action against illegal services - Unenergetic steps of government authorities toward illegal sex determination rackets & illegal distribution of MTP kits by unauthorized person. They are implementing MTP & PCPNDT law on all ready registered RMP clinics & hospital avoiding strict vigilance on illegal activities.
- 6] POCSO confusion - There is major confusion between MTP act & POCSO act. For pregnancy involving minors, RMP must report under POCSO Provisions under laws such as the mandatory reporting requirement under the Protection of Children from Sexual Offences Act (POCSO Act) create additional barriers to accessing safe and legal abortions. Every government authorities know regions in India who practices early marriage. Still they do not

file POCSO cases Sue moto on that person by searching operation. Authorities want RMP to report it to police. It's totally injustice toward safe abortion. They are dragging RMP in legal matter.

So ultimately it causes shortfall of qualified registered medical practitioner and delays women from receiving safe abortion.

#### **Conclusion**

Considering reproductive rights India requires women & RMP friendly ecosystem to uphold abortion care facilities. The journey towards ensuring Sexual and Reproductive Health Rights (SRHR) in India is ongoing, marked by progress yet underscored by persistent challenges. As we navigate the complexities of gender equality, healthcare access, and societal norms, it's imperative to remain steadfast in our commitment to promoting autonomy, dignity, and well-being for all. Involving medical association to form clear fearless guidelines for RMP to protect women's right of reproduction.

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## POCSO ACT AND ITS IMPLEMENTATION WITH PCPNDT & MTP ACT

### Need for POCSO Act, 2012

The Protection of Children from Sexual Offences Act (POCSO Act) 2012 was formulated in order to effectively address sexual abuse and sexual exploitation of All children. It received the President's assent on 19th June 2012 and was notified in the Gazette of India on 20th June, 2012. India is the second largest child population in the world, 42% of India's total population is below eighteen years. Pedophilia has always existed in our country, but recently it has emerged as a disgusting, extremely perverse and inhuman sexual trend.

The Act defines a child as any person below eighteen years of age. It defines different forms of sexual abuse including 1) penetrative assault 2) non-penetrative assault, as well as sexual harassment and pornography. It deems a sexual assault to be "aggravated" under certain circumstances, such as when the abused child is mentally ill or when the abuse is committed by a person in a position of trust or authority like a family member, police officer, teacher, or doctor. This act also lay guideline for general public , police, committees and courts, that, how they have to deal with young rape victim and what procedure to be followed . The Act is applicable throughout the country, now also in the State of Jammu and Kashmir.

### Essentials of POCSO Act, 2012 : WHY REQUIRED ?

- 1]Existing laws (Indian Penal Code (IPC), Information Technology Act, 2000 and Juvenile Justice Act, 2000) were not enough to address sexual offences.
- 2]Apart from framing several statutes, there still existed certain loopholes which were unable to cover provisions related to child sexual abuse , pornography.
- 3] No specific provisions or laws for sexual abuse of male children.
- 4] Section 376 dealt with rape committed with women , it does not specify age.
- 4] The other IPC provisions that are invoked is relating to unnatural practices is Section 377. This section too did not cover forcible sex with a boy amounts to rape and IPC is silent under



this situation.

5] Under Section 67 of the ITAct, 2000, publication and transmission of pornography through the internet is an offence  
 Therefore the Protection of Children from Sexual Abuse Act, 2012 was drafted.  
 Purpose of the Act is to  
 Provide protection to all children from the offences of sexual assault, sexual harassment and pornography.

### Salient Features...

- Child is defined as any person below 18 year of age.
- Clear description and definition of offences.
- Punishment given as per gravity of offence.
- Speedy Trial to be conducted.
- Compensation to victim done
- Avoiding the re-victimization of the child at the hands of the judicial system.
- It provides for Special Courts that conduct the trial in-camera and without revealing the identity of the victim.
- The Act also provides for mandatory reporting of sexual offences.This casts a legal duty upon a person who has knowledge that a child has been sexually abused to report the offence, if he fails to do so, he may be punished with six months' imprisonment or a fine or both.

### Provisions of POCSO

- Police officers must bring every case to the at-

tention of the Child Welfare Committee within 24 hours of receiving a report.

- They must also be in plain clothes while recording the minor's statement so as to not appear intimidating.
- The statement must be recorded in a place chosen by the minor, in the presence of a person that he/she trusts.
- The medico-legal examination for the collection of forensic evidence must be conducted only by a female doctor, in the presence of a person that the minor trusts. Power of Court and procedure followed thereof:
- Female children should be looked after by lady doctor.
- Special courts to conduct trial in camera without revealing child identity.
- At night no child should be detained in the police station.
- The statement of child to be recorded as to spoken by child.
- Child not to be called frequently to testify.

#### **Challenges and limitations faced presently by POCSO ACT**

1. Sexual violence is a significant cause of physical and psychological harm and suffering not only for women and children as also for boys, men and sexual minorities, especially the transgender.
2. The perpetrators range from known relatives, strangers to state agencies to intimate partners; evidence shows that perpetrators are usually persons known to the survivor.
3. POCSO ACT becomes effective only if police complaint or reporting is done
4. Mental trauma, psychological suffering is tremendous and numerous bottlenecks exist.
5. Implementation suffers due to inadequate training of the police and legal authorities
6. Government funds become inadequate for public education to handle child sexual abuse cases.

#### **THE IMPORTANT TERMS –**

7. Survivor--- recognizes that the person is capable of taking decisions despite being victimized, humiliated and traumatized due to the assault' Use of the term survivor is important -- believe the person and not pity her.
8. "Victim" is understood as a person who is not fully capable of comprehending situation at hand because of the victimhood faced., usually brought in by police. Victim also means a person is in need of compassion, care, validation, and support. The belief is that the person is so victimized that she may not be in a frame of mind to make decisions independently. According to POCSO, Act 2012 --Any person (male and female) below the age of 18 years. ;
9. IPC is ( Indian Penal Code 2013)

10. Patient --if a person comes on her own, term patient can be used.

11. Accused: According to POCSO, Act 2012--Any person both male and female, adult or child; IPC 2013--Any male person 18 years ---

#### **Role of Medical Professionals in the context of the POCSO Act, 2012--**

Doctors have a dual role to play in terms of the Sexual Violence & Assaults and POCSO Act 2012.

1] Suspect and detect : They are in a position to detect that a person has been or is being abused (for example, if they come across a person with an STD ); Supposed to be having an in-depth understanding of sexual victimization.

They are also often the first point of reference in confirming that an individual has indeed been the victim of sexual abuse. There are at least three different circumstances when there is no direct allegation but when the obgyn may consider the diagnosis of sexual abuse and have to ask questions of the parent and child.

#### **These include but are not limited to:**

- (i) directly related to the possibility of sexual abuse, such as a girl with a vaginal discharge or minor injuries around vulval areas ;
  - (ii) not directly related to the possibility of sexual abuse, such as abdominal pain or encopresis (soiling);
  - (iii) When a girl has no complaints, but doctor finds an incidental findings such as torn hymen or cigarette burn or scratchmarks :
- 2] Mandatory Reporting – after obtaining a medical history and description of experience in a facilitating, non-judgmental and empathetic manner followed by - differential diagnosis of behavioural complaints and physical signs .

- Formulating a complete and thorough medical report with diagnosis and recommendations for treatment .
- Testifying in court when required

In a case of alleged sexual assault, brought in a private hospital / clinic / nursing home, one can and should do the following in this chronological manner :

- IF brought in by police : Check the vitals of the person first ...if the vitals are stable, the next examination should be after proper consent.
- IF NOT brought by police, but by any other relative or the patient has come on her own : still it is mandatory for a practitioner to examine the patient, even without police requisition, with the consent of the patient
- IN ANY CASE, IF VITALS ARE NOT STABLE --first stabilize the case [In the past rape survivor examination was only done after receiving police requisition. Now the police requisition is not mandatory for a rape survivor to seek medical examination and care. The doctor should examine such cases if the survivor reports to the hospital

first without FIR. He should then inform the police accordingly]

- The victim must be given appropriate treatment [ for injuries , pregnancy , STD , etc ] and counseling as per the need. Victim must not be refused treatment and/ or examination for want of police papers.
- If survivor has come on her own and does not want to file a police complaint ---she should be examined and informed that it is mandatory for a doctor to inform each and every case of sexual assault to police [Mandatory reporting ] Failure to inform such case to police will make doctor liable for any legal complications in future
- NOTE: Absence of injuries over body and/or genitals of the victim of sexual assault does not rule out commission of said offence. Injuries are seen only in 1/3rd of cases and are not the determining factor for sexual assault, in many cases. Few reasons for the absence of injuries are: victim may have been threatened with bodily harm, physically restrained or afraid to/unable to resist for other reasons or intoxication etc.

**CONSENT:** Informed consent of the patient / survivor { guidelines as per Ministry of Health and Family welfare, GOI } for forensic medicolegal examination-

- Should be after giving full information of such examination in vernacular language , or with the help of interpreter.
- If she is less than 12 years of age , or of unsound mind , or intoxicated then consent taken from parents / guardian / officer in charge of hospital RMO /CMO
- No one including Court or police can / should force alleged victim of sexual assault to undergo examination.
- Take consent in front of disinterested witness with name and signature of witness
- Full information regarding concerned procedure to the patient , also give an idea regarding problems arising out of denial,
- If patient still refuses to give consent --then document informed refusal in proforma. Such informed refusal shall be obtained in writing and documented.
- The informed consent also serves as a good legal safeguard for the doctor conducting such procedure.
- If the survivor is less than 18 years age --then her examination should be done by a female RMP doctor ,as per section 27 subsection 2 of POCSO act .
- This information is and should be kept confidential
- Objective of Medical and forensic should be collection of evidence and sending them to Police FSL . SAFE kits are available

#### **WHEN SHOULD THE EXAMINATION BE DONE :**

- If the sexual assault occurred within 72 hours.— ANY-TIME

- Beyond 72 hours if the victim reports:pain or bleeding, an unusual amount of force, ejaculation without cleanup [ Some evidence IS available < 7 days]
- Inform police before discharge , if victim was admitted .

#### **POCSO AND PCPNDT**

Procedure to follow when Radiology & Gynaecology practitioners receive the information about minor's pregnancy when such minor pregnant females approach them either for ANC or for USG or for MTP :

- If a female is between 12 to 18 years of age then her & her guardians written informed consent or denial for disclosing her identity in information given to Police under section 19 (1) of POCSO Act must be obtained.
- If they consent to disclose her identity then it should be disclosed in information given to the police. The format for such written consent to be taken from them & information to be submitted to police . It is available on this link written consent & police information format
- If they deny to disclose her identity then written denial MUST be taken .The format for such written denial to be taken from them & information to be submitted to police. It is available on link written denial & police information format.

#### **POCSO AND MTP**

- Supreme Courts have harmonized POCSO and MTP acts , in 2022 judgement SC has declared Doctors RMPs not to reveal name and identity of Minor / Child in mandatory reporting.under sec 19 of POCSO Act.
- In a 2024 Ruling , SC has emphasized that minor's consent should also be taken regarding her reproductive decisions for her physical and mental wellbeing.
- On 9 December 2024 , Public health department of Maharashtra state government has issued a notification regarding guidelines for actions to be taken by hospitals in MTP cases related to POCSO Act. This contains high court judgements, Supreme Court judgement & booklet issued by MOHFW.

#### **RECENT STATISTICS**

- Total Registered Cases: Over 299,000 cases have been registered since 2019.
- Total Disposed Cases: More than 162,000 cases have been disposed of since 2019.
- Pending Cases: There were 226,728 pending cases as of January 2022, and the number has continued to grow.
- Average Disposal Rate: A 2023 analysis of Fast Track Special Courts (FTSCs) estimated that they were clearing only 28 cases per year on average, significantly lower than the intended rate of 165 cases per year.



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## Strengthening the role and involvement of District-Level Committees in Facilitation of MTP Services Beyond 24 Weeks of Gestation in India

### Introduction

The Medical Termination of Pregnancy (MTP) Act of 1971 and its subsequent amendments have shaped the legal and clinical landscape of abortion care in India. The landmark MTP Amendment Act, 2021 significantly expanded access to safe abortion services by increasing the permissible gestational limits and introducing specialized mechanisms to support decision-making in late-term pregnancies<sup>[3]</sup>.

One of the most consequential provisions of this amendment is the establishment of Medical Boards, often constituted at the district level, to review cases seeking termination beyond 24 weeks on specific grounds such as fetal anomalies. These bodies—commonly functioning as District-Level Committees (DLCs)—play a crucial role in ensuring access, equity, clinical safety, and legal clarity for pregnant women requiring late-term abortion care<sup>[9]</sup>.

As the demand for such services grows, understanding the role and responsibilities of DLCs, and how they facilitate seamless MTP care, becomes essential for policymakers, clinicians, administrators, and public health professionals.

### Legal Foundation for DLCs Under the MTP Amendment Act 2021

The 2021 amendment transformed the legal framework by increasing the upper gestational limit for abortion under certain conditions and by introducing oversight bodies for late-gestation cases<sup>[3]</sup>. Under the amended Act and Rules, termination:

- Up to 20 weeks requires the opinion of one Registered Medical Practitioner (RMP) [1].
- 20–24 weeks requires the opinion of two RMPs for categories of women specified in the Rules, including survivors of sexual assault, minors, differently-abled women, and others<sup>[4]</sup>.
- Beyond 24 weeks, when severe fetal anomalies are diagnosed, the case must be referred to a

Medical Board constituted by the State or Union Territory government<sup>[4][9]</sup>.

These Boards are generally organized at the district level to ensure accessibility and uniformity. They examine medical evidence, evaluate risks, and provide a legally valid opinion on whether termination is permissible, aligning with national abortion-care guidelines and international best practices<sup>[5][6]</sup>.

### Constitution and Structure of District-Level Committees

According to the MTP Amendment Rules (2021), each Medical Board / DLC must include at least:

- A Gynecologist,
- A Pediatrician,
- A Radiologist/Sonologist,
- And any additional experts deemed necessary by the state health authority<sup>[4]</sup>.

This multidisciplinary constitution ensures that decisions on late-term abortions, especially those involving critical fetal abnormalities, are evidence-based, medically sound, and ethically balanced<sup>[9]</sup>.

### Primary Roles and Responsibilities of District-Level Committees

#### 1. Evaluating Requests for MTP Beyond 24 Weeks

The principal role of DLCs is to evaluate applications for termination beyond 24 weeks, specifically in cases of substantiated fetal anomalies<sup>[3][4]</sup>

Their review includes:

- Assessing fetal imaging, anomaly scans, and diagnostic reports,
  - Reviewing maternal health status and potential risks,
  - Determining whether continuation of pregnancy poses physical or psychological harm<sup>[6][9]</sup>.
- This process adds legal clarity for clinicians and protects them from medico-legal complications, while ensuring the patient's reproductive rights

are respected <sup>[7][8]</sup>.

## 2. Ensuring that Decisions are Medically and Ethically Sound

DLCs are responsible for ensuring that decisions comply with national guidelines on Comprehensive Abortion Care (CAC) [5] and consider the WHO's abortion-care standards <sup>[6]</sup>.

Their deliberations often involve:

- Evaluating the severity and prognosis of fetal anomalies,
- Considering viability and post-birth outcomes,
- Balancing maternal autonomy with clinical judgment<sup>[6]</sup>

This multidisciplinary evaluation aligns with global ethical frameworks promoting safe, respectful, and evidence-based abortion access.

## 3. Providing Written, Time-Bound Opinions

The DLC must provide a written opinion within a short, pre-defined timeframe, ensuring timely access to care and preventing delays that could worsen maternal health outcomes <sup>[4][9]</sup>.

Time sensitivity is critical because:

- Termination procedures become more complex as gestation advances,
- Delays can compromise safety and increase emotional distress <sup>[6][10]</sup>.

This time-bound process strengthens accountability and ensures standardized practices across districts.

## 4. Facilitating Referral Pathways to Approved Abortion Facilities

Once approval is granted, DLCs facilitate referral to approved MTP facilities, ensuring that the provider and center are equipped to handle late-gestation abortion care safely<sup>[11][10]</sup>. This coordination includes:

- Linking the patient with tertiary hospitals,
- Ensuring infrastructure such as blood banks, ICU support, and neonatal care (when required),
- Supporting continuity of care from evaluation to post-procedure follow-up.

## 5. Strengthening Clinical Governance and Quality Assurance

DLCs indirectly support quality by monitoring compliance with standards issued under the National Health Mission and CAC guidelines <sup>[10]</sup>.

They also help identify:

- Systemic gaps in fetal anomaly detection,
- Logistical challenges in service delivery,
- Training needs for providers to ensure safe abortion care across all gestational ages.

## 6. Reducing Barriers to Access and Enhancing Equity

DLCs play a crucial role in addressing inequities in abortion access, particularly for women in rural or underserved districts.

By decentralizing decision-making, these committees re-

duce:

- Long-distance travel to state capital-based boards,
- Delays in accessing specialized evaluations,
- Regional disparities in clinical or administrative responsiveness<sup>[7][8]</sup>.

This localized functioning supports reproductive justice and aligns with national public health objectives.

## Impact of DLCs on Safe Abortion Access in India

### 1. Improved Access to Late-Term Abortion

Research suggests that decentralizing decision-making and reducing bureaucratic hurdles improves timely access to critical reproductive healthcare services <sup>[7][8]</sup>. DLCs allow for:

- Faster approval when severe fetal anomalies are detected,
- Support for women with limited mobility or financial resources,
- Greater availability of expert medical review at district level.

### 2. Enhanced Patient Safety

DLC oversight ensures that procedures beyond 24 weeks meet high safety standards and are conducted at facilities equipped to handle late-term cases. WHO emphasizes that timely, safe, and medically supervised abortions significantly reduce maternal morbidity and mortality<sup>[6]</sup>.

### 3. Reduced Legal Ambiguity for Clinicians

Providers often face medico-legal uncertainty in late-term cases. DLCs act as a legal safeguard by offering transparent, documented, and medically justified decisions, reducing litigation risks and allowing clinicians to focus on patient care <sup>[7][9]</sup>.

### 4. Support for Ethical Decision-Making in Complex Cases

DLCs provide a platform for multidisciplinary ethical deliberation, especially in cases involving complex fetal anomalies, maternal risk profiles, or psychosocial vulnerability. Their structured approach aligns with international ethical and medical standards for late-term abortion care <sup>[6]</sup>.

## Challenges Faced by DLCs

Despite their positive impact, DLCs face operational challenges that affect implementation:

- Inconsistent formation across districts leading to variable access <sup>[9]</sup>.
- Delays in convening meetings due to administrative or staffing limitations.
- Limited training regarding fetal anomaly assessment and late-term abortion guidelines <sup>[10]</sup>.
- Resource gaps at referral facilities, especially in rural districts.
- Inadequate data systems preventing monitoring of

case outcomes.

Empirical studies highlight the need for better standardization of Medical Boards to ensure uniform outcomes nationwide<sup>[9]</sup>.

### Recommendations to Strengthen DLC Functioning

1. Uniform SOPs across states for decision timelines and documentation.
2. Training programs for committee members using CAC guidelines and WHO abortion-care modules.
3. Digitized case submission and review systems to reduce delays.
4. Strengthened referral networks ensuring that approved facilities are prepared for late-gestation MTPs.
5. Monitoring and audit mechanisms under NHM to improve quality of care<sup>[10]</sup>.
6. More fetal medicine specialization posts at district hospitals to ensure expert opinion is always available.

### Conclusion

District-Level Committees (Medical Boards) are central to the safe and equitable implementation of the MTP Amendment Act 2021. Their role in providing legally valid, medically sound, and timely opinions for termination beyond 24 weeks has significantly strengthened access to reproductive healthcare in India. By ensuring multidisciplinary evaluation, safeguarding ethical standards, and reducing delays, DLCs uphold the rights, health, and dignity of pregnant individuals facing complex late-term pregnancy scenarios. Continuous investment in training, governance, and health-system capacity will ensure that DLCs realize their full potential in strengthening safe abortion access across the country.

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## Self managed Abortion (SMA) with medical abortion pills: The legal and medical implications, and how it intersects with India's MTP Law.

In India Medical Termination Of Pregnancy is available or allowed legally by MTP Act 1971 under certain indications only and not as wish or demand by the pregnant woman. Under this act self-managed abortion is not allowed. Basically self-managed abortions (SMA) with medical abortion pills are not allowed by law in India and medically also it is not advisable because the complications are known up to death of the patient due to very severe bleeding either vaginally or intra-abdominal due to ruptured ectopic pregnancy or heterotopic pregnancy (one intra-uterine and second one in either of the fallopian tubes). So it is not at all safe without medical expert advice and surveillance.

As per as our today's topic is concerned we will divide it into two parts.

(1) Legal implications and (2) Medical implications.

### (1) Legal implications –

In India, the abortion is considered as woman's right but it is not legally made available on demand of the woman as she wished to have abortion but it is available to needy woman under five indications given in MTP Act 1971 and now for another additional indications in the amendments up to 24 weeks (and above with committee recommendations only). The pills are not available without prescription by an authorized medical practitioner (doctor of MBBS and above qualified only as the medicine's properties are taught during their education of MBBS and above). And to be done in only the approved facility or MTP center. Even the prescriptions must be given through these approved centers. As it is to avoid the maternal morbidity and mortality in India. (Unsafe and ill-legal abortions are contributing around 5 to 13 of the MMR in India as per some researchers in this topic).

The abortion pills in India is under the Schedule H of Drugs and cosmetic act and Rules 1945. This

denotes that the pills are only allowed to be sold by the licensed pharmacist at authorized medical stores and that to with proper prescription by authorized doctor as said above. The pharmacist must keep a copy of the prescription and details in their record as prescribing doctors name, registration number, date and time etc. If this is not followed then it becomes a breach in the law and carries a legal action against involved persons i.e buyer, seller and user of the pills. By the violation of the drug and the cosmetic act 1945, the seller is held responsible but the buyer is not mentioned but under MTP act violation the buyer is not covered under the act protection. This carries criminal liability.

The MTP act covers the legal MTP but when an action out of the MTP law is taken place then there can be application of IPC 312 to 318 (IPC 1860) and 88 to 94 (BY Bharti Nyay Sanhita) as it is illegal, voluntary, without consent and not done by registered medical practitioner under MTP Act 1971. This may lead to serious legal actions.

Whenever such pills taken patient goes to any hospital for the complaints like Bleeding in majority cases or pain in abdomen or incomplete abortions then the hospital administration must report this ill-legal abortion in MLC to police. If not done and any complication takes place then the liability is with the doctor of the treating hospital.

### (2) Medical implications –

The basic of MTP is that it is to be done by registered Medical Practitioner under his or her observation because it is not that simple as it seems. The pregnancy can be Intrauterine, Ectopic or Heterotopic (One pregnancy is in uterus and second is ectopic or extrauterine). The self-administration of MTP pills may lead to complications and may lead to fatal conditions. The complications are as follows.

1) Failure of procedure – In India pills are al-

lowed as per MTP act up to 9 weeks only. If the pills are not taken as per the guidelines then failure chances are more or the incomplete abortions are more resulting in additional procedure of evacuation or repeat pills dose. This leads to economic, psychological, and physical trauma at times.

2) Severe Bleeding and shock- In certain circumstance the bleeding starts and becomes severe then the physical condition of the patient is in dangerous situation with risk of life also if not tackled properly .

3) Rupture of tubes or at times uterus also- When the abortion pills are taken by patients on their own they do not have proper knowledge about the protocols. They do not know about the place of the pregnancy. It can be in the uterus or it can be in the tubes as in ectopic pregnancy. If it is intrauterine and the dose is taken as per the protocols then there are more chances of complete abortion but if the pregnancy is ectopic and is in the tubes then the tubes get ruptured and intra-abdominal bleeding may take place leading to anemia and hemorrhagic shock. In Majority of cases it is reported late as bleeding is not seen openly and so the complications are bound to be there. The third condition is more serious one. If it is heterotopic pregnancy then the intrauterine one gets aborted and ectopic gets ruptured. Patients thinks that the abortion is complete but the internal bleeding is in continuation and may lead to severe shock. In certain situations it is seen that the rupture of uterus also taken place due to the unscrupulous use of pills

4) Infection of genitourinary tract and if not tackled timely may lead to sepsis and septicemia. Incomplete abortions or complete with continuous bleeding afterwards without medical care and surveillance may lead to severe infections and complications. The chronic infections may lead to fibrosis of Genito-urinary system and may lead to infertility in further obstetric life.

So at the end we can say that in India Self-managed Abortion (SMA) with medical abortion pills are illegal according to the MTP Act 1971 and not at all advisable. A publication is published on 11 May 2023 as original article (in JSAFOG.com) by Neha Thakur, Ritu Shilp Verma and Tripti Nagaria under the heading as "Self-administration of abortion pills and its maternal outcome in tertiary care center." They conclude with "Abortion pills should be banned as over-the-counter drug, strict surveillance is required for the same. It should reach the public only through approved medical termination of Pregnancy centers after prescription. Society need to be educated for the risk of self intake of abortion pills and their dangerous consequences. MTP should be done under strict vigilance.

Another publication is available on PMC (PubMed Cen-

tral) which has conducted a survey by 33 semi-structured interview with range of providers (medical, community health and pharmacy) in Jharkhand, Bihar and Tamil Nadu. The title is "Supporting self managed abortion care in "practice not premise" a qualitative study of provider perspective, roles, and information pathway to care in India." by Laura E Jacobson, Calia Brander and others (PMCID : PMC12351739 PMID: 40689560).

The self-medication for MTP with pills in India is not legal and even the promotion of such act is also not acceptable.

Public awareness about the availability of legal MTP at Government hospitals and in private recognized hospitals must be increased by various method. It should be available easily and accessible to general woman.

From my side the last sentence would be, **"In India Self-managed Abortion (SMA) with medical abortion pills are illegal according to the MTP Act 1971 and not at all advisable in view of medical complications seen at various instances."**

**Disclaimer- We are not criticizing or opposing to any body's opinion but has given only facts present in India under legal framework.**

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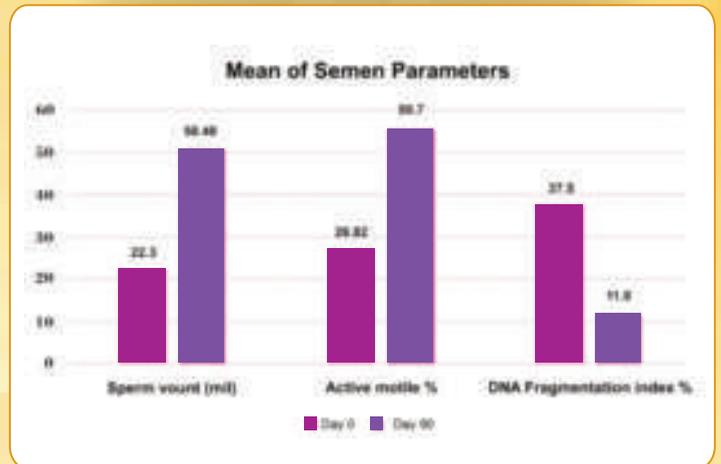
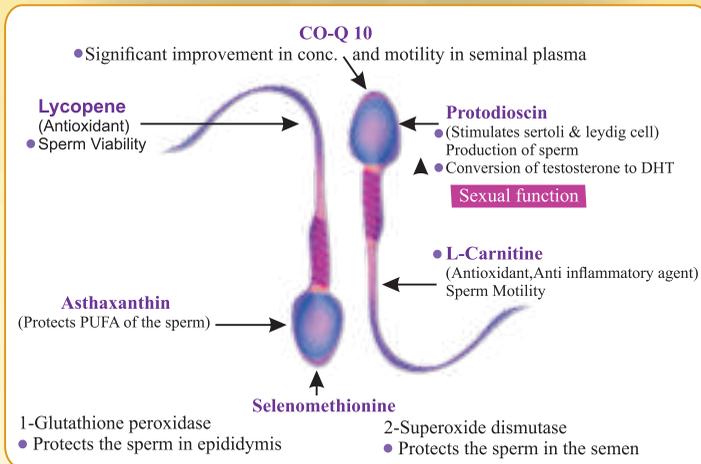
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